

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 9 7 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7 22 1979		M	
Nellie Mae ANDERSON							
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
female		white		MONTH DAY YEAR Sept. 4, 1893		85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Ohio		USA				Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		427 Crain Highway		housewife (ret)		own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
		MD		AA		Glen Burnie	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		427 Crain Highway	
William E. Hall		Lenora Lynn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
NO		XXXXXXXX 02080244930		Mr. Ray R. Anderson (son)		same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4409		left ventricular failure				minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)	
		coronary arteriosclerosis				years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
				8/23 76 7/20 79			
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		19 79		19 79		that (I) (we) lost	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
MAX C. FRANK				7/23/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
		425 E. Hatcher Hwy - Glen Burnie MD 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY	
Burial		July 26, 79		Bethel Cemetery		Baileys Mills Belmont OHIO	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REG. NO.	
Singleton Funeral Home, Glen Burnie, MD				JUL 24 1979			

21-81

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15974

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN.
VERA L. AVERILL					7	23	79		11	00
3. SEX	RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE	WHITE	2-9-04		75		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Mich.	USA			AA Co						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				MD
Annapolis	A-H. Genl. Hosp.			Clerk		Dept Store				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
md	aa	Arnold			1436 Gilbert St.					
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Wendell		Wittae	Mabel		Crawford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no	385031259		Mafine Corp		Baltimore					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pneumonia</u> 5559 DUE TO, OR AS A CONSEQUENCE OF (b) <u>inamitition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>regional enteritis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 d 3 ins. 5 yrs.										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH * DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
						7/23/79				
22a. I certify that (1) (this hospital) attended the deceased from 5/1/79 to 7/23/79, that (1) (we) lost saw the deceased alive on 7/23/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
Wm A Cassio		M.D.				7/26/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Wm A Cassio		2510 Riva Rd Annapolis								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE
Burial		7-27-79		Lakewood		Lakewood		Annapolis		MD
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Robert S Baranco		JUL 30 1979		Loring McCurdy						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 1 5 9 7 5 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Francis X. Bachmaier, Sr.</i>					2a DATE OF DEATH MONTH DAY YEAR <i>July 11, 1979</i>					2b HOUR M
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>February 11, 1902</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Germany</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.				
10 CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT INSURANCE FACILITY, GIVE STREET ADDRESS) <i>North Anundel General Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Office Worker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Education</i>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i>					13b COUNTY <i>Anne Arundel</i>		13c CITY OR TOWN <i>Pasadena</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Albert Bachmaier</i>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine Unknown</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b SOCIAL SECURITY NO. <i>220-30-4701</i>		17 INFORMANT ADDRESS <i>Mr. Francis X. Bachmaier, Jr. 7998 Willow Oak Pasadena, Md. 21122</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Metastatic adenocarcinoma of Max. Anus</i>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <i>10-12</i> , 19 <i>78</i> , to <i>7-6</i> , 19 <i>79</i> , that (I) (we) last saw the deceased on <i>7-6</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)										
22b SIGNATURE <i>[Signature]</i>		DEGREE <i>[Signature]</i>		22c. DATE SIGNED <i>7/12/79</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert G. Lisk, M.D.</i>				22e. ADDRESS <i>7300 Ritchie Highway Glen Burnie, Md. 21061</i>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>7/14/79</i>		23c NAME OF CEMETERY OR CREMATORY <i>St. John's Cath. Cem.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Hyde Baltimore Md.</i>				
24 FUNERAL DIRECTOR NAME <i>Mc Cully Funeral Home of Pasadena</i>				25a DATE REC'D. BY REGISTRAR <i>JUL 18 1979</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>				

[illegible]

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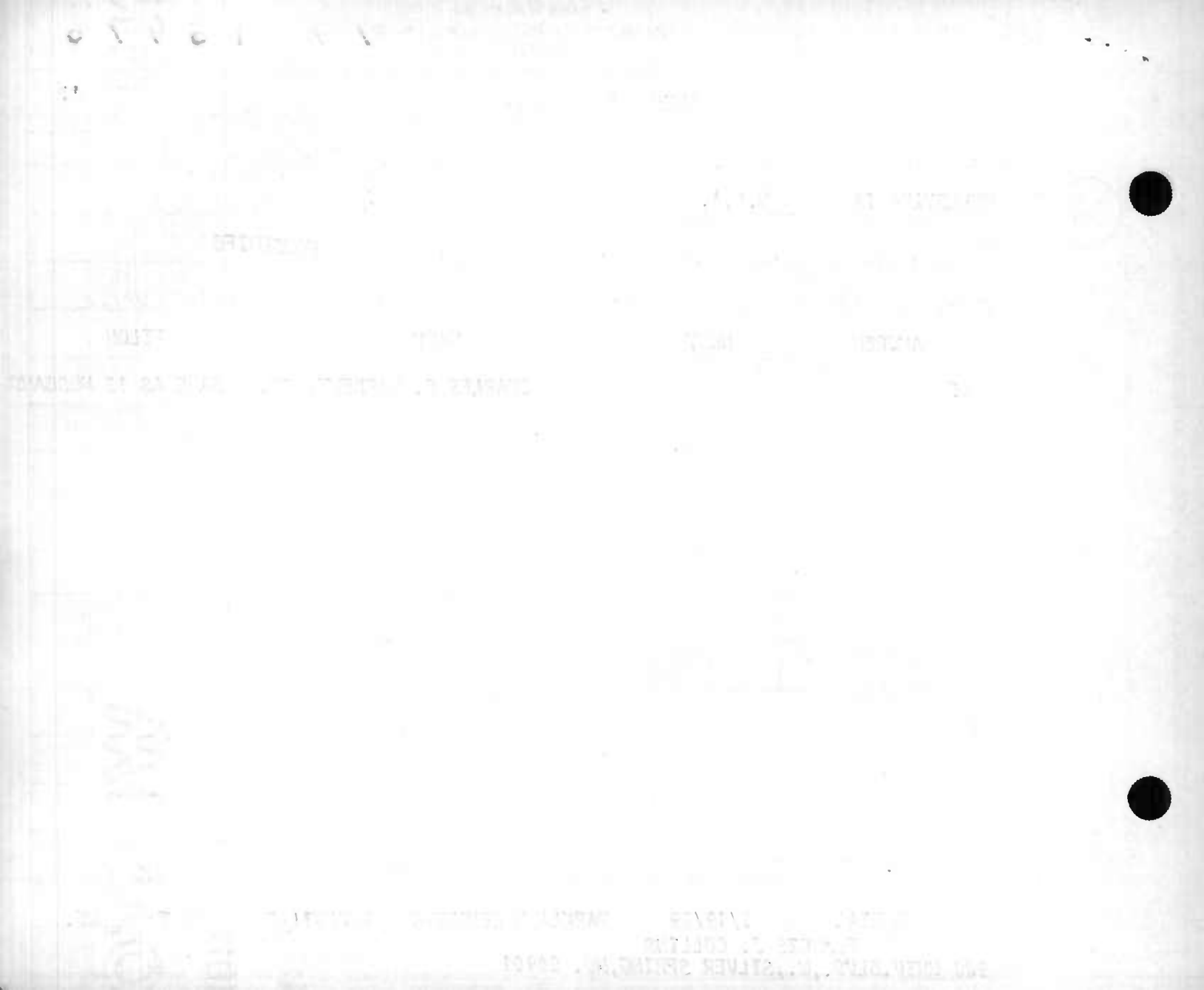
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 5 9 7 6			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dorothy AGNES Barrett</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 16, 1979</b>		2b. HOUR <b>4 45</b> M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 - 7 - 22</b>		6 AGE (IN YEARS (LAST BIRTHDAY)) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10 CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>				13b COUNTY <b>A.A.</b>		13c CITY OR TOWN <b>Edgewater</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>ANDREW HUNT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>MARY FILON</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>517-24-9686</b>		17 INFORMANT ADDRESS <b>CHARLES C. BARRETT, SR. SAME AS 13 HUSBAND</b>			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pontine Hemorrhage</b> <b>431-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>7/9</b> 19 <b>79</b> to <b>7/16</b> 19 <b>79</b> that (I) (we) last saw the deceased alive on <b>7/15</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jack Kushner</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JACK KUSHNER</b>				22e. ADDRESS <b>20 Ridge 14 Annapolis</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/19/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT MD.</b>	
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert K. B.</b>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15977		DST			
1. FOR STATE REGISTRAR										2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA Claudine BICKEL										7 14 '79		8 20 AM			
3. SEX female		4. RACE white		5. DATE OF BIRTH Feb. 2, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.									
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) secretary (ret)		12b. KIND OF BUSINESS OR INDUSTRY Prakes & Controls							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 403 E. Maple Road			
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Linthicum Hts											
14. FATHER'S NAME FIRST MIDDLE LAST Rixem R. Garey					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Rawlings										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) XXXXXXXX 217/05/5754		17. INFORMANT ADDRESS A Mr. F.D. Bickel (husband) same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>7-11-79</u> to <u>7-14-79</u> , that (I) (we) lost saw the deceased alive on <u>7-13-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Jack I. Stern</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>7-14-79</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack I. Stern, M.D.						22e. ADDRESS 300 Hospital Dr. #135 Glen Burnie, Md. 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 17, 79		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD							
24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home</u> ADDRESS Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR JUL 16 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 5 9 7 8					
1. FOR STATE REGISTRAR		REG. NO.								DST.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
WILETTA		E.				BILLINGS		7		14	1979	7:47 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		Feb. 28, 1920		59 YRS.		MONTHS		DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.			
Penna.		U.S.A.				ANNE ARUNDEL									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Glen Burnie		NORTH ARUNDEL HOSPITAL		Wireperson		Electronics									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Maryland		A.A.		Hanover		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		739 L.S. Camelot Court							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
William		Etta													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
no		178-20-5210		Everett Billings		same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration &amp; Acidosis</u> 1550 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary Carcinoma of the Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 months</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
5-21-79										Carcinoma 1 liver		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>July 14</u> , 19 <u>79</u> , to <u>July 14</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>July 14</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22b. SIGNATURE <u>E. Roderick Shipley</u> M.D.		22c. DATE SIGNED <u>July 14 1979</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
E. Roderick Shipley, M.D.										529 S. Camp Meade Rd. Linthicum Heights, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial										7/17/79		Mt. Zion Cemetery		Mahanoy, Clearfield, Pa.	
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Raymond C. Fink										JUL 18 1979		<u>John H. H. H.</u>			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 9 7 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Louisa Kasten BLANKE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 18, 1979</b>			2b. HOUR M <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 29, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.				
10. CITY OR TOWN OF DEATH <b>Pasadena</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1721 Grandview Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1721 Grandview Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Kasten</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dora Hesse</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>217-03-8685</b>			17. INFORMANT <b>Mr. Ewald O. Blanke (Husband)</b>			ADDRESS Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC PYELONEPHRITIS &amp; UREMIA</b> 4292 DUE TO, OR AS A CONSEQUENCE OF <b>A S C V D.</b> (b) <b>PARKINSON DISEASE</b> (c) <b>10 yr</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b> 1 yr										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>7/10</b> , 19 <b>79</b> , to <b>7/17</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7-10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Norman R Kleiman MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/18/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NORMAN R KLEIMAN MD</b>			22e. ADDRESS <b>3803 EDMONDSON AVE</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>21 JUL '79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR'S NAME <b>SINGLETON FUNERAL HOME, Glen Burnie, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1979</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 15980

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL V BOWEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-30-79</b>		2b. HOUR <b>2:40 A M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2-18-1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL CO. MD.</b>	
10. CITY OR TOWN OF DEATH <b>CROWNSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAIRFIELD NURSING CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H.W.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>@ Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>SEVERNA PARK</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>517 OWENS WAY-21146</b>
14. FATHER'S NAME <b>Jacob Brewer</b>			15. MOTHER'S MAIDEN NAME <b>Emma Magarum</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216053805B</b>		17. INFORMANT <b>Earl A Bowen - above</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b> <b>15 years</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>79</b> , to <b>30 July</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>30 July</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>T.C. Cullis MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T.C. Cullis MD</b>		22e. ADDRESS <b>7 Riggs Ave Severna park Md.</b>	

23a. BURIAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-1-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>
24. FUNERAL DIRECTOR NAME <b>BARRANCO F.H.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 2 1979</b>	
ADDRESS <b>Severna Pk. Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Henry M. ...</b>	

The medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9		1 5 9 8 1		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARIE F.		MIDDLE BROOKS		2a. DATE OF DEATH MONTH DAY YEAR 7-31-79		2b. HOUR 2:45 P.M.	
3. SEX F		4. RACE N		5. DATE OF BIRTH MONTH DAY YEAR 8 30 1904		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 45 Bloomsbury Square	
14. FATHER'S NAME FIRST MIDDLE LAST PERRY DAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE DAY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Maryland CHARLES CONNER 45 Bloomsbury Sq. Annapolis							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 586- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anthony J. Calabrese M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c. DATE SIGNED 7/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY J CALABRESE				22e. ADDRESS 2510 RVA Road Annapolis 20714					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8-3-1979		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md.				25a. DATE REC'D. BY REGISTRAR AUG 02 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 5 9 8 2

1. DECEASED NAME (TYPE OR PRINT) WILSON JOHN BROWN, JR.			2a. DATE OF DEATH MONTH DAY YEAR JULY 3, 1979			2b. HOUR 6:30 A.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 18, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6506 South Charter Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFEUR		12b. KIND OF BUSINESS OR INDUSTRY GREYHOUND	
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLENBURNIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILSON J. BROWN, SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE ROTHENBERGER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946-1950		17. INFORMANT ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION 11/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/78, 19 to 7/3, 1979, that (I) (we) last saw the deceased alive on 6/23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Cecilia				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3 JUL 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CECILIA A. COW				22e. ADDRESS lands, Md. 4000 Annapolis Road, Baltimore High-				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5 JUL 79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN PARK A.A. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS SINGLETON FUNERAL HOME, GLENBURNIE, MD.				25a. DATE REC'D. BY REGISTRAR JUL 5 1979				
				25b. REGISTRAR'S SIGNATURE R. H. H. H.				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DST

1. FOR STATE REGISTRAR		7 9 1 5 9 8 3	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST ADDA PEARL BURKHART		MONTH DAY YEAR July 2, 1979	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Female	White	MONTH DAY YEAR Aug. 18, 1899	79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Pa.	U.S.A.		Anne Arundel County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Glen Burnie	North Arundel Hospital		Housewife
12b. KIND OF BUSINESS OR INDUSTRY	12c. OWN HOME		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Pa.	Blair	Altoona	YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Frank Prough		FIRST MIDDLE LAST Mary Lane	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT (daughter) ADDRESS	
no	n/a	Mrs. Bonnie Barclay Altoona, Pa.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 486- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Symptoms of Acute Coronary</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?
			YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>7/2</u> 19 <u>79</u> , to <u>7/2</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>7/2</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	22c. DATE SIGNED
<u>Robert B. Kroopnick</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	<u>7/2/79</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
ROBERT B. KROOPNICK, MD.		205 Baltimore-Annap. Blvd. Glen Burnie, Maryland, 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	6/1979	Carson Valley Cem.	Allegheny Blair Pa.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
<u>R. H. Hopkins</u>		<u>JUL 5 1979</u>	<u>[Signature]</u>
Singleton Funeral Home Glen Burnie, Md.			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 5 9 8 DS4

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR			
LAWRENCE ALBERT BURLEY			JULY			4, 1979			9:35PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Black		9 17 79		61			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Seven, Md		USA				ANNE ARUNDEL						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL				Laborer			Construction			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Queenstown, Rd Harmon, Md			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
Ervin						Lucinda						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No						215-28-7006		Marie B. Burley, Harmon, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Respiratory system infection</u>												
2749 DUE TO, OR AS A CONSEQUENCE OF												
(b) <u>Hypertensive heart disease with cerebral infarction</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF												
(c) <u>Stroke</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Few hours												
5 gm												
5 gm												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
Paul Chang									7/5/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			22f. DATE REC'D. BY REGISTRAR			
DR. PAUL CHANG						801 CRAIN HWY., S.E.			JUL 6 1979			
23a. BURIAL, CREMATION, REMOVAL						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial						7/9/79		ST Resto		Honover A.A. Md		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Turnell B. Oden - 4161 E. Edmond St						JUL 6 1979			[Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LIBRARY OF THE  
U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
DENVER, COLORADO

STEN BUREAU NORTH AVENUE HOSPITAL

CR. 9-UL. CHANG

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 777  
(VR A 15 (4))



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 9 8 5

REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST HARRY	MIDDLE BUSCH	LAST BUSCH	2a. DATE OF DEATH	MONTH JULY	DAY 17	YEAR 1979	2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH FEB. 24, 1920	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.								
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipyard		12b. KIND OF BUSINESS OR INDUSTRY Md. Drydock						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1953 Venetian Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST Vondenbousch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 01 7863		17. INFORMANT ADDRESS Shirley Busch same as 13 e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 410 - DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Stenosis with aortic valve purchased 20 yrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Atrial fibrillation, heart failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (the hospital) attended the deceased from 5-17 19 75, to 5-17 17 79, that (1) (the last saw the deceased alive on 5-14 10 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) did not view the body after death, so state.)											
22b. SIGNATURE Louis E. Grenzer		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/19/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis E. Grenzer		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/20/79		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.					
24. FUNERAL DIRECTOR NAME George J. Gonce		ADDRESS Balto 21225 4001 Ritchie Hgwy		25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE R. J. H. H. H.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						7 9 1 5 9 8 6 REG. NO. DST					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EUGENE CAMPBELL</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 7, 1979</b>				2b. HOUR <b>1:00 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 5, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>59</b>		IF UNDER 1 YEAR MONTHS DAYS <b>59</b>		IF UNDER 24 HRS. HOURS MIN. <b>59</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KENTUCKY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AIRPORT SECURITY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>city PD</b>			
13a. STATE <b>MARYLAND</b>						13b. CITY OR TOWN <b>ANNE ARUNDEL GLEN BURNIE</b>		13c. STREET ADDRESS <b>515 DOGWOOD DRIVE, S.W.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM CAMPBELL</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCY SAMPSON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						16b. SOCIAL SECURITY NO. <b>W.W.II 405 01 0467</b>		17. INFORMANT ADDRESS Same as # 13 <b>MRS. LOUISA E. CAMPBELL (WIFE)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410 - Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DEATH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>5/24/79</b> to <b>July 7, 1979</b> , that (I) (we) last saw the deceased alive on <b>5/24/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE OF PHYSICIAN <b>Jorge B. Ramirez M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/8/79</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>						23b. DATE <b>11 JUL '79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, Md. A.A. Co.</b>	
24. FUNERAL DIRECTOR NAME <b>SINGLETON FUNERAL HOME, Glen Burnie, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>			

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ANNE ARUNDEL COUNTY

NORTH BRANCH HOSPITAL

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1965 B. FORMER N.C.

NOTED ON FILE



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15987  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Rehnd W Campbell</b>			7a. DATE KNOWN OF DEATH ESTIMATED <b>7 10 79</b>			7b. HOUR <b>A</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>29</b> YEAR <b>32</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>46 YRS</b>	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>	IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>	7c. DATE PRONOUNCED DEAD <b>7 10 79</b>		7d. HOUR <b>P</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>B. P. D.</b>		
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3569 Fort Meade Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Proprietor-sales</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Lawrence M.</b> MIDDLE <b>Campbell</b> LAST <b>Campbell</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Lila M.</b> MIDDLE <b>Mairs</b> LAST <b>Mairs</b>			16. ADDRESS <b>Laurel, Md.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>072-26-8090</b>		17. INFORMANT <b>Lila W. Campbell</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9554</b> IMMEDIATE CAUSE (a) <b>gun shot wound</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>gun shot wound</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>gun shot wound</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>7</b> A.M. MONTH <b>10</b> DAY <b>79</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Self inflicted gun shot wound</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN <b>Laurel</b> COUNTY <b>ANNE</b> STATE <b>MD</b>		21g. ADDRESS <b>3569 Fort Meade Rd.</b>	
22a. I certify that I took charge of the remains described above, held on death resulted from <b>gun shot wound</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <b>E. L. Linhardt</b>			TITLE (SPECIFY) <b>MD. Deput Secy</b>			DATE SIGNED <b>7-10-79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>E. L. Linhardt</b>			ADDRESS <b>Laurel, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Md</b>	
24. FUNERAL DIRECTOR NAME <b>Dippel Brothers, Inc</b> ADDRESS <b>7110 Belair Rd. 21206</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 5 9 8 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Jeremy William Casby</u>				2a. DATE OF DEATH MONTH <u>July</u> DAY <u>5</u> YEAR <u>1979</u>		2b. HOUR <u>5:45</u> M	
3. SEX <u>male</u>		4. RACE <u>Cauc.</u>		5. DATE OF BIRTH MONTH <u>7</u> DAY <u>5</u> YEAR <u>79</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <u>4</u> <u>26</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel Co.</u> MD.	
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel Gen. H.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u>Anne Arundel</u> 13c. CITY OR TOWN <u>Riviera Beach</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>245 Glenwood Rd.</u>	
14. FATHER'S NAME FIRST <u>James</u> MIDDLE <u>W.</u> LAST <u>Casby</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Paula</u> MIDDLE <u>S.</u> LAST <u>Casby</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Paula S. Casby</u>		ADDRESS <u>Casby</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE CONGENITAL ANOMALIES</u> <u>7597</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. Hewitt M.D. by M. Benson M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b. DATE <u>7/9/79</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <u>Anatomy Board</u> ADDRESS <u>Balto., Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>JUL 16 1979</u>		25b. REGISTRAR'S SIGNATURE <u>L. H. McCreedy</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.		15989		D.S.T.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM T CARBACK, SR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 3, 1979</b>		2b. HOUR <b>4:16 A.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 15 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERVISOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R.R.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>PASADENA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Rt. 11 BOX 72 COLONIAL BEACH</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ELISHA W. CARBACK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY ANN WASHBURN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-07-7250</b>		17. INFORMANT ADDRESS <b>MARY E. CARBACK, RT. 11 BOX 72, PASADENA</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Massive Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Recep Erol</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RECEP EROL, M. D.</b>		22e. ADDRESS <b>325 HOSPITAL DRIVE, SUITE 103 GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>07-05-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.,</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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WILLIAM THOMAS CARBACK, SR. JULY 3, 1973 4:18

CLEN EURNIE NORTH ARUNDEL HOSPITAL ANNE ARUNDEL COUNTY

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 9 9 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Walter T. Carroll Jr.</b>			2a. DATE OF DEATH MONTH <b>July</b> DAY <b>17</b> YEAR <b>79</b>			2b. HOUR <b>7:45 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>9</b> YEAR <b>1918</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>61</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Arundel</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3031 Tarpon Road</b>			
14. FATHER'S NAME FIRST <b>Walter</b> MIDDLE <b>T.</b> LAST <b>Carroll Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Blanche</b> MIDDLE <b>May</b> LAST <b>Quackerbush</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW 11 577 09 8141</b>		17. INFORMANT <b>Clarence C. Carroll</b>				18. ADDRESS <b>1022 Challedon Road Great Falls, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphoma</b> 2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1978</b> , 19____, to <b>7/17/79</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/12/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Stanley P. Watkins, M.D.</b>						DEGREE		22c. DATE SIGNED <b>7/17/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stanley P. Watkins, M.D.</b>						22e. ADDRESS <b>121 Cathedral St. Annapolis, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham P.G. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Francis Gasch's Sons Funeral Home, P.A.</b> ADDRESS <b>Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>P. H. B. B.</b>		

BP

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*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
15M 7/76

DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH	
HARTFORD		T.		Carter				20. DATE KNOWN OF DEATH	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE PRONOUNCED DEAD	
Male		Negro		2 12 1950		29 YRS.		7 9 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
D.C.		U.S.A.		WIDOWED		DIVORCED		Anne Arundel County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel General Hospital							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		A.A.		ANNAPOLIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1285 Graft Court	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
HARTFORD		HAZEL		YES		214-56-0933		SYLVIA CARTER	
T.		CONWAY		VIETNAM				1285 Graft Ct. Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:	
4643		4643		4643		4643		4643	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
Acute epiglottitis		Acute epiglottitis		Acute epiglottitis		Acute epiglottitis		Acute epiglottitis	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(b)		(b)		(b)		(b)		(b)	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(c)		(c)		(c)		(c)		(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20. AUTOPSY?		20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		P.M. 19						21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an		22a. I certify that I took charge of the remains described above, held an		22a. I certify that I took charge of the remains described above, held an		22a. I certify that I took charge of the remains described above, held an		22a. I certify that I took charge of the remains described above, held an	
death resulted from:		death resulted from:		death resulted from:		death resulted from:		death resulted from:	
Natural causes <input checked="" type="checkbox"/>		Natural causes <input checked="" type="checkbox"/>		Natural causes <input checked="" type="checkbox"/>		Natural causes <input checked="" type="checkbox"/>		Natural causes <input checked="" type="checkbox"/>	
Accident <input type="checkbox"/>		Accident <input type="checkbox"/>		Accident <input type="checkbox"/>		Accident <input type="checkbox"/>		Accident <input type="checkbox"/>	
Suicide <input type="checkbox"/>		Suicide <input type="checkbox"/>		Suicide <input type="checkbox"/>		Suicide <input type="checkbox"/>		Suicide <input type="checkbox"/>	
Homicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Homicide <input type="checkbox"/>	
Undetermined manner <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>	
22b. I certify that I took charge of the remains described above, held an		22b. I certify that I took charge of the remains described above, held an		22b. I certify that I took charge of the remains described above, held an		22b. I certify that I took charge of the remains described above, held an		22b. I certify that I took charge of the remains described above, held an	
Autopsy <input checked="" type="checkbox"/>		Autopsy <input checked="" type="checkbox"/>		Autopsy <input checked="" type="checkbox"/>		Autopsy <input checked="" type="checkbox"/>		Autopsy <input checked="" type="checkbox"/>	
Inspection <input type="checkbox"/>		Inspection <input type="checkbox"/>		Inspection <input type="checkbox"/>		Inspection <input type="checkbox"/>		Inspection <input type="checkbox"/>	
Inquiry <input type="checkbox"/>		Inquiry <input type="checkbox"/>		Inquiry <input type="checkbox"/>		Inquiry <input type="checkbox"/>		Inquiry <input type="checkbox"/>	
and in my opinion		and in my opinion		and in my opinion		and in my opinion		and in my opinion	
TITLE (SPECIFY)		TITLE (SPECIFY)		TITLE (SPECIFY)		TITLE (SPECIFY)		TITLE (SPECIFY)	
M.D. Assistant		M.D. Assistant		M.D. Assistant		M.D. Assistant		M.D. Assistant	
DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED		DATE SIGNED	
7/10/79		7/10/79		7/10/79		7/10/79		7/10/79	
EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S NAME (TYPE OR PRINT)	
Ann M. Dixon, M.D.		Ann M. Dixon, M.D.		Ann M. Dixon, M.D.		Ann M. Dixon, M.D.		Ann M. Dixon, M.D.	
ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS	
111 Penn St.		111 Penn St.		111 Penn St.		111 Penn St.		111 Penn St.	
Balto., MD.		Balto., MD.		Balto., MD.		Balto., MD.		Balto., MD.	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE	
BURIAL		7-13-1979		St. Rest Cemetery		Harmans		Maryland	
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
WILLIAM REESE & SONS MORTUARY, P.A.		WILLIAM REESE & SONS MORTUARY, P.A.		WILLIAM REESE & SONS MORTUARY, P.A.		WILLIAM REESE & SONS MORTUARY, P.A.		WILLIAM REESE & SONS MORTUARY, P.A.	
25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR		25a. DATE REC'D. BY REGISTRAR	
JUL 12 1979		JUL 12 1979		JUL 12 1979		JUL 12 1979		JUL 12 1979	



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15992	
1. DECEASED NAME (TYPE OR PRINT) <b>Reuben A CAVEY</b>										2a. DATE KNOWN OF DEATH ESTI- MATED <b>7 2 1979</b>										2b. HOUR <b>A M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 19 14</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD <b>7 2 1979</b>		2d. HOUR <b>A M</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.									
10. CITY OR TOWN OF DEATH <b>Riviera Beach</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lake Drive = HOME</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Mechanic</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>					
13a. STATE <b>Md.</b>				13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Riviera Bch</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>225 Lake Rd. Riviera Bch.</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Reuben Cavey</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Cavey</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II 213 01 1273</b>		17. INFORMANT ADDRESS <b>Marie Cavey same as 13 e</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Bladder</b> <b>1889</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>yrs.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) <b>Depot 9</b> M.D.				MEDICAL EXAMINER				DATE SIGNED <b>7-2-79</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt</b>				ADDRESS <b>Annapolis, Md.</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/5/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>											
24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hgwy</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1979</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>													

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DST

1. DECEASED NAME (TYPE OR PRINT) Homer John Charles			2a. DATE OF DEATH MONTH DAY YEAR July 7, 1979			2b. HOUR 11:11P M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) transportation		12b. KIND OF BUSINESS OR INDUSTRY US Gov.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN A.A. Co.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 976 Annapolis Rd.			
14 FATHER'S NAME FIRST MIDDLE LAST Homer W. Charles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Brooks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Robert R. Smithsame as 13e.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>ESPAD</u> (c) <u>ESPAD</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/7/79</u> 19 <u>79</u> , to <u>7/7/79</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7/7/79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Jorge B. Ramirez</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7/8/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jorge B. Ramirez M.D.				22e. ADDRESS 325 Hospital Drive #207 Glen Burnie, Md. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/11/79		23c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Ann. Md.				ADDRESS 12 Ridgely Ave.		25a. DATE REC'D. BY REGISTRAR JUL 11 1979		25b. REGISTRAR'S SIGNATURE <u>Hardesty</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 7/78



BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15994											
1. DECEASED NAME (TYPE OR PRINT) <b>ASA</b>										2a. DATE KNOWN OF DEATH <b>7 4 79</b>										2b. HOUR <b>A</b>											
3. SEX <b>M</b>		4. RACE <b>N</b>		5. DATE OF BIRTH <b>4 6 06</b>		6. AGE (IN YEARS) <b>73</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>7 4 79</b>		2d. HOUR <b>A</b>																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>										7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <b>XX</b> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A.Co.</b>									
10. CITY OR TOWN OF DEATH <b>Seaborn</b>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North. Howard. Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ODENTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Box 388 Rt. 1</b>																							
14. FATHER'S NAME <b>WILLIAM</b>										15. MOTHER'S MAIDEN NAME <b>MARY CHISLEY</b>																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>										16b. SOCIAL SECURITY NO. <b>717-07-6712</b>										17. INFORMANT <b>EDWARD CHISLEY</b>		ADDRESS <b>1837 Circle Rd. Severn, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE <b>Coronary atherosclerosis CV8</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										19. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on										Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <b>E. Linhart</b>										TITLE (SPECIFY) <b>M.D. Deputy</b>										DATE SIGNED <b>7-4-79</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhart</b>										ADDRESS <b>Annapolis, Md.</b>																					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>										23b. DATE <b>7-7-1979</b>										23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns UM Church Ceme</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Odenton Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>										ADDRESS <b>Annapolis, Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>JUL 5 1979</b>										25b. REGISTRAR'S SIGNATURE <b>E. Linhart</b>	



Checked

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Submarine and Naval Light

Box 386 14.1

WILLIAM H. HARRIS & SONS, INC. CHICAGO, ILL.

1917-1918

Patented July 1918

Patented

Patented July 1918

WILLIAM H. HARRIS & SONS, INC. CHICAGO, ILL. JUL 2 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					7 9 1 5 9 9 5 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Tena G. Cierniak					2a. DATE OF DEATH MONTH DAY YEAR July 12, 1979					2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.					
10. CITY OR TOWN OF DEATH Brooklyn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5226 Sixth Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5226 Sixth Street 21225			
14. FATHER'S NAME FIRST MIDDLE LAST Unkwon Grabowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ----- 220-48-2413		17. INFORMANT ADDRESS 129 Drexel Drive Millersville Mrs. Genevieve Kellenberger Md. 21108							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4273 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Abnormal Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1951</u> , 19____, to <u>11 July</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>11 July</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Andrew R. Sasnowski MD</u> DEGREE						22c. DATE SIGNED 7/15/79			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew R. Sasnowski						22e. ADDRESS 4016 Ritchie Hwy Balto - 21225 Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/16/79		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Anne Arundel Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Mcully Funeral Home of Curtis Bay 4200 Pennington Ave. Balto., Md. 21226						25a. DATE REC'D. BY REGISTRAR JUL 18 1979			25b. SIGNATURE <u>[Signature]</u>		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR Items 18a. 21a. - 21f										DEPARTMENT OF HEALTH AND MENTAL HYGIENE		15996					
1- STATE REGISTRAR Film#G533 as 7-16-79										MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>R.D. Clark</b>								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>7</b> DAY <b>3</b> YEAR <b>1979</b>		2b. HOUR <b>M</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>14</b> YEAR <b>1919</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>60 YRS.</b>		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		2c. DATE PRONOUNCED DEAD MONTH <b>7</b> DAY <b>3</b> YEAR <b>1979</b>		2d. HOUR <b>7:30 p.m.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Canton N. C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundle Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Odenton</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>501 Prince Charles St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gas Station= Owner</b>				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>				13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Odenton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>501 Prince Charles Ave.</b>							
14. FATHER'S NAME FIRST <b>Benjamin</b> MIDDLE <b>Harrison</b> LAST <b>Clark</b>								15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b></b> LAST <b>Presley</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>45-42</b>		17. INFORMANT <b>Josephine S. Clark</b>				ADDRESS <b>same as 13e.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wounds of chest (Handgun)</b> <b>9550</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:30 p.m. 7 3 1979</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>shot self.</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>at home</b>				21f. LOCATION STREET <b>501 Prince Charles St.</b>		CITY OR TOWN <b>A.A.</b>		COUNTY <b>Md.</b>		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>J.R. Guard</b>				M.D. <b>Assistant</b>				MEDICAL EXAMINER				DATE SIGNED <b>7-4-79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN <b>Suitland Md.</b>				COUNTY <b></b>		STATE	
24. FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home</b>				ADDRESS <b>12 Ridgely Ave. Ann. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Kathy Brandy</b>					



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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

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501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600

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701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800

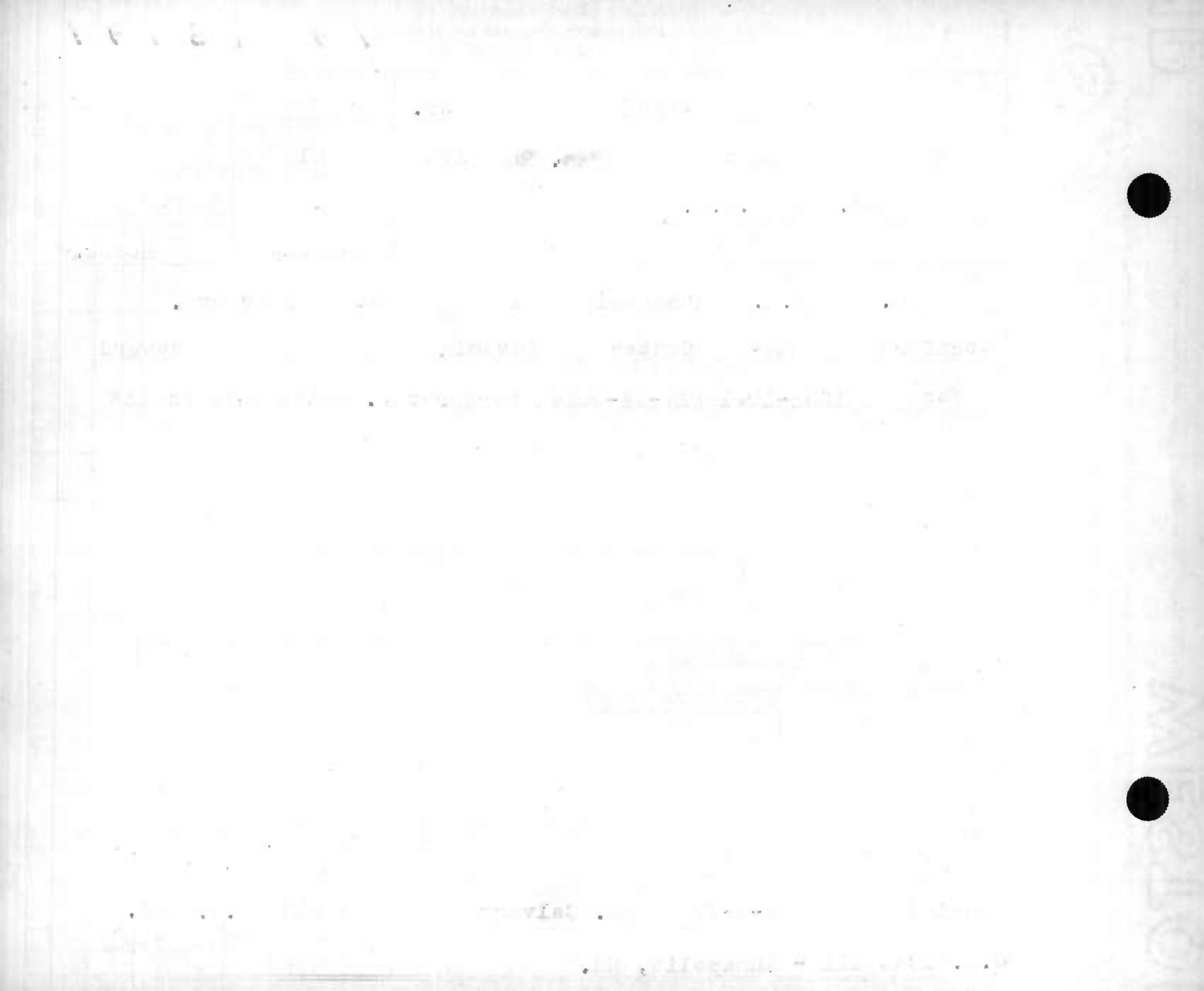
801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7	9	1	5	9	9	7
FOR 1- STATE REGISTRAR										REG. NO. DST						
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR P.		
GEORGE Edward COATES Jr.										July 31, 1979				10:20 M.		
3 SEX			4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.			
Male			Black		JUL 28 1928			51 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Md.			U.S.A.						Anne Arundel County, MD.							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie			North Arundel Hospital							Laborer			*****			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					Md.		A.A.		Annapolis				13e. STREET ADDRESS			
													208 Parker Ave.			
14 FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Stanford nmnn Coates					Luvenia nmnn Howard											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					17 INFORMANT ADDRESS						
Yes					1953-1961					217-24-9006A Margaret L. Coates Same as 13E						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Huntington chorea</u> 3334 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Mental retardation</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u>										22c. DATE SIGNED <u>8/1/79</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SASANT KHANDLWAL</u>										22e. ADDRESS <u>205 Baltimore-Annapolis Blvd. Glen Burnie, Maryland, 21061</u>						
DALJIT S. SAWHNEY, MD.																
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial			8-4-79			Mt. Calvary			Arnold A.A. Md.							
24 FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
C.E. NICKS 111 - Annapolis, Md.										AUG 13 1979			<u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 5 9 9 8 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Hennietta P Collinson					2a. DATE OF DEATH MONTH DAY YEAR 7 21 79			2b. HOUR M		
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR June 21 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.				
10. CITY OR TOWN OF DEATH Fair Haven		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rural				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md					13b. CITY OR TOWN Fair Haven		13c. STREET ADDRESS Rural		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles M. Root					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie M. Owing					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 36 9121		17 INFORMANT ADDRESS Joseph F. Collinson Jr. Fair Haven, Denton Md						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Vascular disease 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/10 1979, to 7/21/79 1979, that (I) (we) last saw the deceased alive on 7/21 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. Weems			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Weems			22e. ADDRESS Huntingtown Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 24 79		23c. NAME OF CEMETERY OR CREMATORY Friendship Church		23d. LOCATION CITY OR TOWN COUNTY STATE Friendship A.A. Md			
24. FUNERAL DIRECTOR NAME Ransom Funeral Home Owing						25a. DATE REC'D. BY REGISTRAR JUL 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1- FOR STATE REGISTRAR			7 9 1 5 9 9 9				REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
Annie			Creek						7/22/79		5:45am		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR 8. UNDER 24 HRS	
Female			NEGRO			8 6 12			66			MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND			U.S.A.						ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
ANNAPOLIS			ANNE ARUNDEL GENERAL HOSPITAL										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
MARYLAND			A.A.			ANNAPOLIS					10 1/2 Dorsey Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
JOSEPH			SIMMS			MARTHA			PARKER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
NO						Andrew Creek 10 1/2 Dorsey Ave. Annapolis, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u>										30 min			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD, asthma</u>										Several years			
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Pt recently hospitalized for bronchiectasis + given tracheostomy</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> , 19 <u>79</u> , to <u>7/22</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>7/22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Thomas Marrell Holl, MD</u> DEGREE _____						22c. DATE SIGNED <u>7/22/79</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS MARRELL HOLL, MD</u>						22e. ADDRESS <u>134 OWENSVILLE RD. WEST RIVER Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>7-26-1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHEWS CHURCH CEME.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Owensville Maryland</u>					
24. FUNERAL DIRECTOR NAME <u>WILLIAM REESE &amp; SONS MORTUARY, P.A.</u> ADDRESS <u>Annapolis, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>JUL 24 1979</u>		25b. REGISTRAR'S SIGNATURE <u>History McBrady</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Info. added per phone call  
Anatomy Bd. 8/1/79 re

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

16000

1. DECEASED-NAME (Type or print) <i>Mabel J. Curry</i>			2a. DATE OF DEATH Month <i>7</i> Day <i>25</i> Year <i>1979</i>			2b. HOUR <i>7:30 A M</i>					
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 22, 1893</i>		6. AGE (In years lost birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>ANNE ARUNDEL</i> Md.					
10. CITY OR TOWN OF DEATH <i>GLEN BURNIE</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MD MANOR</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>ANNE ARUNDEL</i>		13c. CITY OR TOWN <i>GLEN BURNIE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <i>214-22-4423</i>			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>410-</i> DUE TO, OR AS A CONSEQUENCE OF <i>ASCD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 HR</i> <i>10 min</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>12-8</i> , 19 <i>78</i> to <i>7-25</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>7-25</i> , 19 <i>79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>MB Pearlman</i>			DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>7-25-79</i>		
22d. PHYSICIAN'S NAME (Type) <i>MB PEARLMAN</i>			22e. ADDRESS <i>5400 DICKINSON</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>			23b. DATE <i>July 25, 1979</i>			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>Anatomy Board 655 W. Balto. St. Balto. Md.</i>			ADDRESS			25a. REC'D BY REGISTRAR DATE <i>AUG 2 1979</i>			25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>		

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 16001

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSA E. CURTISS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 21 79</b>			2b. HOUR <b>9 55</b> <small>AM</small>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 05 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>0 0 0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Salisbury, Maryland Box 36 Cedar Hurst Village</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-07-6731B</b>		17. INFORMANT ADDRESS <b>Mr. William J. Curtiss Same as #13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> 1541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of rectum</b> 10 yr. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , to <b>7-21</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>7-20</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <b>Barber C. Palmer</b>			22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barber C. Palmer M.D.</b>			22c. DATE SIGNED <b>7-21-79</b>		22d. ADDRESS <b>801 Melvin Ave Annapolis</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 24, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Anne Arundel Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Mc Cully Funeral Home of Brooklyn</b>			24b. ADDRESS <b>237 E. Patapsco Avenue Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>21225 JUL 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 6 0 0 2				D.S.T.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR A.M.			
1. DECEASED NAME FIRST MIDDLE LAST BENJAMIN NMN DAVIS				JULY 13, 1979				4:10 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fred. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Self. Emp.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS E Howard Rd.			
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Glen Burnie							
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin L. Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada L. Peters							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213 01 7683 A		17. INFORMANT ADDRESS Mr. Howard J. Davis 25 Belmore Rd. Lutherville, Md. 21093							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7854 IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION 7-27-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric ulcer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>7-23-79</u> to <u>7-13-79</u> , that (1) (we) last saw the deceased alive on <u>7-13-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael B. Pearlman				DEGREE M.D.				22c. DATE SIGNED 7-13-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL B. PEARLMAN, M.D.				22e. ADDRESS 205 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 16, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Md.					
24. FUNERAL DIRECTOR NAME G. Truman Schwab				ADDRESS 5151 Balto. National Pike Balto. Md. 21229				25a. DATE REC'D. BY REGISTRAR JUL 17 1979		25b. REGISTRAR'S SIGNATURE L. H. McCreedy	

BP



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MICHAEL R. DEARLMAJ, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

16003

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
John c. Diamond				7/18/79		4:25		4:25	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE	WHITE	MONTH DAY YEAR		61 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH			
Georgia		USA				Anne Arundel County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel General		State of Md. Special Police					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		47 McPherson Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Yes		WW II		Virginia E. Diamond (same as 13e)	
Dominos John Diamond		Caroline Brown				122-12-8640			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) 410- CVA									
DUE TO, OR AS A CONSEQUENCE OF (b) MI									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/17/79, 19, to 7/18/79, 19, that (I) (we) last saw the deceased alive on 7/18/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
S.P. WATKINS		fa Da Biem		7/18/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
S.P. WATKINS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		07-20-79		Hillcrest Cemetery		Annapolis, Anne Arundel, Md.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Beall Funeral Home, 1212 West St., Anna., Md.		JUL 23 1979		L. J. McCready					





Items #5a-22a Film G534 8/27/79 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16004

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH		KNOWN ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
WILLIAM D. DUPLAYEE								7		13		19		79				9:00 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
male	white	7 29 1934		44 YRS.						7		13		19		79			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Wise		USA		WIDOWED		DIVORCED		Anne Arundel County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY													
Crofton		1510 Lowell Ct.		USD Ret.															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS											
MD.		AA		Annapolis		YES		445 Poplar LA.											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
JOYCE		HELEN		YRS KOREA - 1978		390 327110		FRANCES E. Duphaye		#13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Acute propoxyphene intoxication																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION																			
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																			
20. AUTOPSY?																			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																			
21b. TIME OF INJURY																			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK																			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																			
21f. LOCATION																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE																			
TITLE (SPECIFY)																			
DATE SIGNED																			
EXAMINER'S NAME																			
ADDRESS																			
23a. DATE OF CREMATION REMOVAL																			
23b. NAME OF CEMETERY OR CREMATOR																			
23c. LOCATION																			
23d. COUNTY																			
23e. STATE																			
23f. DATE REC'D. BY REGISTRAR																			
23g. REGISTRAR'S SIGNATURE																			

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M7/77

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16005			
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH						ESTIMATED		MONTH DAY YEAR		2b. HOUR					
JAMES Lacey						EASTER						7 31 79						19		M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD						MONTH DAY YEAR		2d. HOUR							
MALE		WHITE		June 24, 1938		41 YRS.		MONTHS DAYS HOURS MIN.		7 31 79						19		M		7:37							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH								MD							
Alabama				USA								ANNE ARUNDEL															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY															
ANNE ARUNDEL				ARUNDEL GENERAL HOSPITAL				Civilian Personnel				USAF															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																			
MARYLAND		ANNE ARUNDEL		ARNOLD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1262 CATHY DRIVE																			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																					
FIRST MIDDLE LAST						FIRST MIDDLE LAST																					
James Barrett Easter						Ethel Louise Lacey																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT						ADDRESS									
no						424 48 7775						Barbara L. Easter, #13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE																											
4292 DUE TO, OR AS A CONSEQUENCE OF																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																											
(b) DUE TO, OR AS A CONSEQUENCE OF																											
(c)																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?									
																		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
						HOUR A.M. MONTH DAY YEAR																					
						P.M. 19																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION															
												STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED															
Key to Dr. Krell						ASSISTANT						8-1-79															
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS																					
MARGARITA KORELL, M.D.						111 PENN STREET, BALTO., MD.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION									
Burial						8-3-79						Elmwood Cemetery						Birmingham Jefferson Alabama									
24. FUNERAL DIRECTOR NAME						ADDRESS						25a. DATE REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE									
Hardesty FH, 12 Ridgely Ave, Annapolis, Md, 21401												AUG 03 1979						F. H. Hardesty									

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TO HOSPITAL: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 16006

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frederick G Ecken Sr</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 8 79</b>			2b. HOUR <b>11:10 AM</b>					
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 13 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A.A. GEN Hospt.</b>				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Service</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>				13b. CITY OR TOWN <b>ANNAPOHIS</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>SILVERWOOD Circle</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRED A ECKEN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOTTIE PARKINSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>WW II 216 449065</b>		17. INFORMANT ADDRESS <b>IDA E. ECKEN #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding Diathesis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pancytopenia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic Prostatic Carcinoma</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:29 79</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1616 Forest Drive Annapolis MD</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/7</b> 19 <b>79</b> , to <b>7/8</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7/7</b> 19 <b>79</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Georg C. Samaras</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/8/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George C. Samaras</b>			22e. ADDRESS <b>1616 Forest Drive Annapolis MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7/11/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis MD MD</b>		
24. FUNERAL DIRECTOR NAME <b>John M. Sykes</b>						25a. DATE RECEIVED BY REGISTRAR <b>JUL 11 1979</b>					
ADDRESS <b>Chesapeake, MD</b>						25b. REGISTRAR'S SIGNATURE <b>Anthony J. Brady</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 16007			
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES EMERSON ELLIOTT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 9, 1979</b>				2b. HOUR <b>5:15 A.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 3 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.					
10. CITY OR TOWN OF DEATH <b>CROWNSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CROWNSVILLE HSP. CNT.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARPENTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BOAT BUILDING</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>CALVERT</b>		13c. CITY OR TOWN <b>BROOME ISLAND</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 11, Broome Island, Md 20615</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES R. ELLIOTT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VICTORIA C. ELLIOTT</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-12-0189</b>		17. INFORMANT ADDRESS <b>MARTIN E. ELLIOTT / BROOMES ISLAND, MARYLAND</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>pneumonia</b> (c) <b>Diabetes mellitus</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2105</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i.e.) <b>Diffuse anoxic encephalopathy, alcoholic (chronic)</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>7-8-1979</b> to <b>7-9-1979</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>7-8-1979</b> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <b>Muradaddin M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>7-9-1979</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NUREDDIN ERK</b>				22e. ADDRESS <b>CROWNSVILLE HSP. CNT. CROWNSVILLE 21052 Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JULY 11, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BROOMES ISLAND CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BROOMES IS. CALVERT MD.</b>					
24. FUNERAL DIRECTOR NAME <b>DONALD V. BORGWARDT</b>				ADDRESS <b>PORT REPUBLIC, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9

1 6 0 0 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARION A. ENGELKE</b>			2a. DATE OF DEATH MONTH <b>7</b> DAY <b>8</b> YEAR <b>79</b>		2b. HOUR <b>AM</b>
3. SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>19</b> YEAR <b>05</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS <b>73</b> DAYS <b>73</b> HOURS <b>73</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>200 Hilltop LA</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD.</b>	13b. CITY OR TOWN <b>AA Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>200 Hilltop LA.</b>		
14. FATHER'S NAME FIRST <b>HARRY</b> MIDDLE <b>JEWELL</b> LAST <b>ENGELKE</b>	15. MOTHER'S MAIDEN NAME FIRST <b>BERTHA</b> MIDDLE <b>GRIFFITH</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>280-28-8968</b>	17. INFORMANT ADDRESS <b>HARRY J. ENGELKE #13</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>0119</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Tbc.</b> (c) <b>6 mos</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 25 1979</b> to <b>July 19 79</b> , that (I) (we) last saw the deceased alive on <b>June 25 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Rodney L. Brimhall MD</b>				22c. DATE SIGNED <b>7/8/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RODNEY L. BRIMHALL</b>				22e. ADDRESS <b>Forest Dr Annapolis MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>7/10/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST MARYS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD</b>	
24. FUNERAL DIRECTOR NAME <b>John M. Souter</b> ADDRESS <b>1400 Souter Rd</b>				25a. DATE OF REGISTRATION <b>JUL 11 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Barry McCreedy</b>	



CH 1 April 12 1952  
CH 1 April 12 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79 16009			
1. DECEASED NAME (TYPE OR PRINT) <b>DAISY MAY FIELDS</b>				2a. DATE OF DEATH MONTH <b>July</b> DAY <b>20</b> YEAR <b>1979</b>				2b. HOUR <b>6:20</b> MIN <b>A</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>30</b> YEAR <b>1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>A. A.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7987 Nolpark Court Apt. 202</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>H.</b> LAST <b>Lilley</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Nellie</b> MIDDLE <b>=</b> LAST <b>Howard</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>219-18-8625</b>		17. INFORMANT ADDRESS <b>Darlene Wilson 7991 Nolpark Ct. G. B.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer lung</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-21</b> , 19 <b>79</b> , to <b>7-12</b> , 19 <b>79</b> , that (I) (we) lost <b>2-12-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>SEENIVASAN</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/20/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SEENIVASAN</b>				22e. ADDRESS <b>615, Hammond Lane, BALTO, 21225</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/23/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd Cem.</b>		23d. LOCATION CITY OR TOWN <b>Ellicott City</b> COUNTY <b>Howard</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Raymond C. Fink</b>				ADDRESS <b>Glen Burnie, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Rafaela...</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		D.S.T.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LOUISE Martha FINCK</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 13, 1979</b>				2b. HOUR <b>12:30<sup>A</sup></b>							
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 23, 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS HOURS MIN.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>															
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>										13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Crownsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1185 St. Stephens Church Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Beyer</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Rhode</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-36-9166</b>				17. INFORMANT ADDRESS <b>Mrs. Elizabeth Terifay, 21061 214 Vernon Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic Ca breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <b>July 9, 1979</b> to <b>July 13, 1979</b> , that (I) (we) last saw the deceased alive on <b>July 13, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <b>Paul S. Rhodes M.D.</b>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL S. RHODES, M. D.</b>										22e. ADDRESS <b>1667 CROFTON CENTER CROFTON, MARYLAND 21114</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>16 July 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, AA Md.</b>											
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>JULY 18, 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

MEDICAL CERTIFICATION





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 6 0 1 1	
1 - FOR STATE REGISTRAR		REG. NO.								DST	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM SAMUEL FISHPAW</b>						2a DATE OF DEATH MONTH DAY YEAR <b>July 4, 1979</b>				2b HOUR P. <b>5:10 M.</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05-01-09</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD.</b>					
10 CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Towing Service</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Arnold</b>						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>192 Via Dante</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Beverly J. Fishpaw</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Jones</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>220-07-2168A</b>		17 INFORMANT <b>Catherine I. Fishpaw (same as 13e)</b>				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5-712</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>11</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <b>Chronic Coronary Artery Disease</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>6-11-79</b> , to <b>7-4-79</b> , that (I) (we) last saw the deceased alive on <b>7-4-79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Hilary T. O'Herlihy</b>						DEGREE		22c. DATE SIGNED <b>7-4-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HILARY T. O'HERLIHY, MD.</b>						22e. ADDRESS <b>325 Hospital Drive, #208 Glen Burnie, Maryland, 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>07-07-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, Anne Arundel, Md.</b>					
24 FUNERAL DIRECTOR NAME ADDRESS <b>Beall Funeral Home, 1212 West St., Anna., Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Luttrell</b>			

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UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D.C. 20315



1	2	3	4	5	6	7	8	9	10	11	12
[Faint, illegible text and markings throughout the form grid]											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16012	
1. DECEASED NAME (TYPE OR PRINT) <b>Val Anthony Fitzgerald</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		MONTH DAY YEAR <b>7 29 1979</b>		2b. HOUR <b>4:25 P</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 29, 1948</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>7 30 19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alaska</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Severna Park</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Jonas Green State Park</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Custodian P.G. Co. Schools</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12912 Fletchertown Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Fitzgerald</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mercedes C. Fletcher</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-48-8159</b>		17. INFORMANT <b>Bowie, Maryland</b> <b>William H. Fitzgerald, 12912 Fletchertown</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <b>9102</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>7:15</b> P.M. MONTH DAY YEAR <b>7 29 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>drowned while swimming</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>river</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Severna Park, A.A. MD</b>					
22a. I certify that I took charge of the deceased described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>7/31/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn ST. Balto., MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 3, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ascension Church Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bowie, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert G. Beall Lanham Funeral Home 9013 Annapolis Rd., Lanham, Maryland</b>						25a. DATE <b>Aug 6 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

## SUMMARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 16013		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAGARET FOOTE				2a. DATE OF DEATH MONTH DAY YEAR 7 15 79		2b. HOUR A M 4 A			
3 SEX FEMALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 / 12 / 05		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co. MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.				13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GALESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES TALBOT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE STEWART					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 214-03-5153		17. INFORMANT ADDRESS ARTHUR FOOTE 963 W. Benning Rd. Galesville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/40 CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JULY 5, 19 79, to JULY 15, 19 79, that (I) (we) lost the deceased alive on JULY 14, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE KEVIN O'Rourke MD				DEGREE MD		22c. DATE SIGNED 7/15/79		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN O'ROURKE, MD				22f. ADDRESS 1620 ANGUS G., CROFTON, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-19-1979		23c. NAME OF CEMETERY OR CREMATORY CHEWS CHURCH CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Owensville Maryland		23e. DATE REC'D. BY REGISTRAR JUL 20 1979	
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.				ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE [Signature]			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 16014	
1. DECEASED NAME (TYPE OR PRINT) Rosetta M Forrester			2a. DATE OF DEATH MONTH DAY YEAR 7 23 79			2b. HOUR 12 <sup>40</sup> / <sub>PM</sub>					
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 2 2 42		6 AGE (IN YEARS LAST BIRTHDAY) 37 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) A. C. General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN A.A.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5936 Tyler Rd. Minneca Cove					
14 FATHER'S NAME FIRST MIDDLE Thomas Forrester		15 MOTHER'S MAIDEN NAME FIRST LAST Mary Foote									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-40-3363		17 INFORMANT Mary Forrester-Deale, Md.				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 3989 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF b) <u>(2) Atrial enlargement + atrial fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>Possible rheumatic heart ds.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Unknown</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Bronchopneumonia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> 19 <u>77</u> , to <u>7-23</u> 19 <u>79</u> that (I) (we) lost saw the deceased alive on <u>7-23</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David Krims</u>		DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/25/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S.D. KRIMS, M.D.</u>				22e. ADDRESS <u>ANNE ARUNDEL Gen. Hosp.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>7/27/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chews Mem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Dyersville A.A. Md.</u>					
24 FUNERAL DIRECTOR <u>William Fessenden Mort. Co., - Anns. Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>JUL 24 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Henry K. Brady</u>					

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 FOR  
1- STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 16015

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED MONTH DAY YEAR		2b. HOUR	
MYRTLE L. FULKOSKE								DATE MATED		7 18 79		P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR		8. IF UNDER 24 HRS		9. DATE PRONOUNCED DEAD		10. HOUR	
FEMALE	WHITE	03 12 1899		80 YRS.						7 18 79		P	
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		12. CITIZEN OF WHAT COUNTRY?		13. MARRIED		14. NEVER MARRIED		15. DIVORCED		16. BALTIMORE CITY OR COUNTY OF DEATH		17. MD.	
MARYLAND		U.S.A.		MARRIED		NEVER MARRIED		DIVORCED		Anne Arundel CO			
18. CITY OR TOWN OF DEATH		19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		21. KIND OF BUSINESS OR INDUSTRY		22. ADDRESS		23. CITY		24. STATE	
Glen Burnie		North-Arundel		SALESLADY		GOLDBERG &		133 MARGARET DRIVE		15010		CO.	
25. STATE		26. COUNTY		27. CITY OR TOWN		28. INSIDE CITY LIMITS?		29. STREET ADDRESS		30. CITY		31. STATE	
PENNSYLVANIA				BEAVER FALLS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		133 MARGARET DRIVE		15010		CO.	
32. FATHER'S NAME		33. MOTHER'S MAIDEN NAME		34. WAS DECEASED EVER IN U.S. ARMED FORCES?		35. SOCIAL SECURITY NO.		36. INFORMANT		37. ADDRESS		38. DATE	
CLIFTON D. SEWELL, SR.		LENA E. HEINER		NO		216-40-1076		MELVA L. HOMENS		7104 WASHINGTON BLVD.			
39. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Multiple Injuries													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
40. DATE OF OPERATION		41. CONDITION FOR WHICH OPERATION WAS PERFORMED?		42. AUTOPSY?		43. YES <input type="checkbox"/> NO <input type="checkbox"/>		44. DATE		45. TIME		46. LOCATION	
47. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		48. TIME OF INJURY		49. HOW INJURY OCCURRED		50. PLACE OF INJURY		51. LOCATION		52. CITY OR TOWN		53. COUNTY	
7-15-79		P.M.		Route 177 on L. Fairview Rd		MD							
54. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		55. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		56. LOCATION		57. CITY OR TOWN		58. COUNTY		59. STATE		60. DATE	
61. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
62. ACTUAL SIGNATURE		63. TITLE (SPECIFY)		64. DATE SIGNED		65. MEDICAL EXAMINER		66. ADDRESS		67. CITY		68. STATE	
E. L. IMPROST		M.D.		7-18-79		Annapolis		MD					
69. EXAMINER'S NAME (TYPE OR PRINT)		70. DATE		71. NAME OF CEMETERY OR CREMATORY		72. LOCATION		73. CITY		74. COUNTY		75. STATE	
E. L. IMPROST		07-23-79		LOUDON PARK		BALTIMORE CITY		MARYLAND					
76. FUNERAL DIRECTOR		77. ADDRESS		78. DATE REC'D. BY REGISTRAR		79. REGISTRAR'S SIGNATURE		80. DATE		81. TIME		82. LOCATION	
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		JUL 23 1979		Annapolis							



*C. G. Brown*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 1 6 0 1 6 REG. NO.				DST		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES D. FUNKHOUSER						2a. DATE OF DEATH MONTH DAY YEAR July 22, 1979			2b. HOUR P. 6:50 M.
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-25-09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY AA 13c. CITY OR TOWN Arnold						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 1 Box 329	
14. FATHER'S NAME FIRST MIDDLE LAST Franklin M Funkhouser						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1		17. INFORMANT ADDRESS Kathline Funkhouser - above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 1589 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction, Pericardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 7-15-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute surgical abdomen				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 7-17-79, to 7-26-79, that (1) (we) last saw the deceased alive on 7-26-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles R. MacDonald MD DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-23-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES R. MacDONALD, MD.						22e. ADDRESS 325 Hospital Drive, #204 Glen Burnie, Maryland, 21061			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 7-25-79		23c. NAME OF CEMETERY OR CREMATORY Grace Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Md Jackson Va			
24. FUNERAL DIRECTOR NAME Paul S. Buranco Severna Park						25a. DATE REC'D. BY REGISTRAR JUL 30 1979		25b. REGISTRAR'S SIGNATURE [Signature]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 16017

1. DECEASED NAME (TYPE OR PRINT) <b>ISABEL E. GAMBLE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 14 79</b>			2b. HOUR <b>7:30</b> M			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 10 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HUNTER HUNDEL MD.</b>			
10. CITY OR TOWN OF DEATH <b>St. Michaels</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1652 PLEASANT PLAINS RD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>St. Michaels</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1652 PLEASANT PLAINS RD.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE DAVIDSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ISABEL EMORY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT ADDRESS <b>WM DAVIDSON #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>D.O.A.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACVD - paroxysmal</b>									20 yrs
(c) <b>Fibrillation &amp; CH3</b>									2 wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypothyroidism</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-13-79</b> to <b>7-16-79</b> , that (I) (we) lost saw the deceased alive on <b>7-13-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frank M. Shipley MD.</b>						DEGREE <b>MD.</b>		22c. DATE SIGNED <b>7-16-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F.M. Shipley</b>						22e. ADDRESS <b>Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL			23b. DATE <b>7/16/79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. James</b>			23d. LOCATION <b>St. James</b>
24. FUNERAL DIRECTOR <b>John M. Taylor</b>			ADDRESS <b>St. James, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Harry M. ...</b>	

BP



V I O L E T

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16018	
1. DECEASED NAME (TYPE OR PRINT) <b>Myers Edward Gardner</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>7 5 1979</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>28</b> YEAR <b>18</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>61</b> YRS.		7. IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		2b. DATE PRONOUNCED DEAD MONTH <b>7</b> DAY <b>5</b> YEAR <b>79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>1A. P. CO.</b>	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Howard Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>M.T.A.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>				13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7965 Phirne Road</b>	
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b>Gardner</b> LAST <b>Gardner</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Edna</b> MIDDLE <b>Myers</b> LAST <b>Myers</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>217.05.2959</b>		17. INFORMANT ADDRESS <b>Annapolis, Md.</b> <b>Mr. Edward W. Gardner (son)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) <b>M.D. Reps 19</b>				DATE SIGNED <b>7.5.79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt</b>				ADDRESS <b>Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 9, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Singleton</b> ADDRESS <b>Funeral Home, Glen Burnie, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Edgar H. Brady</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

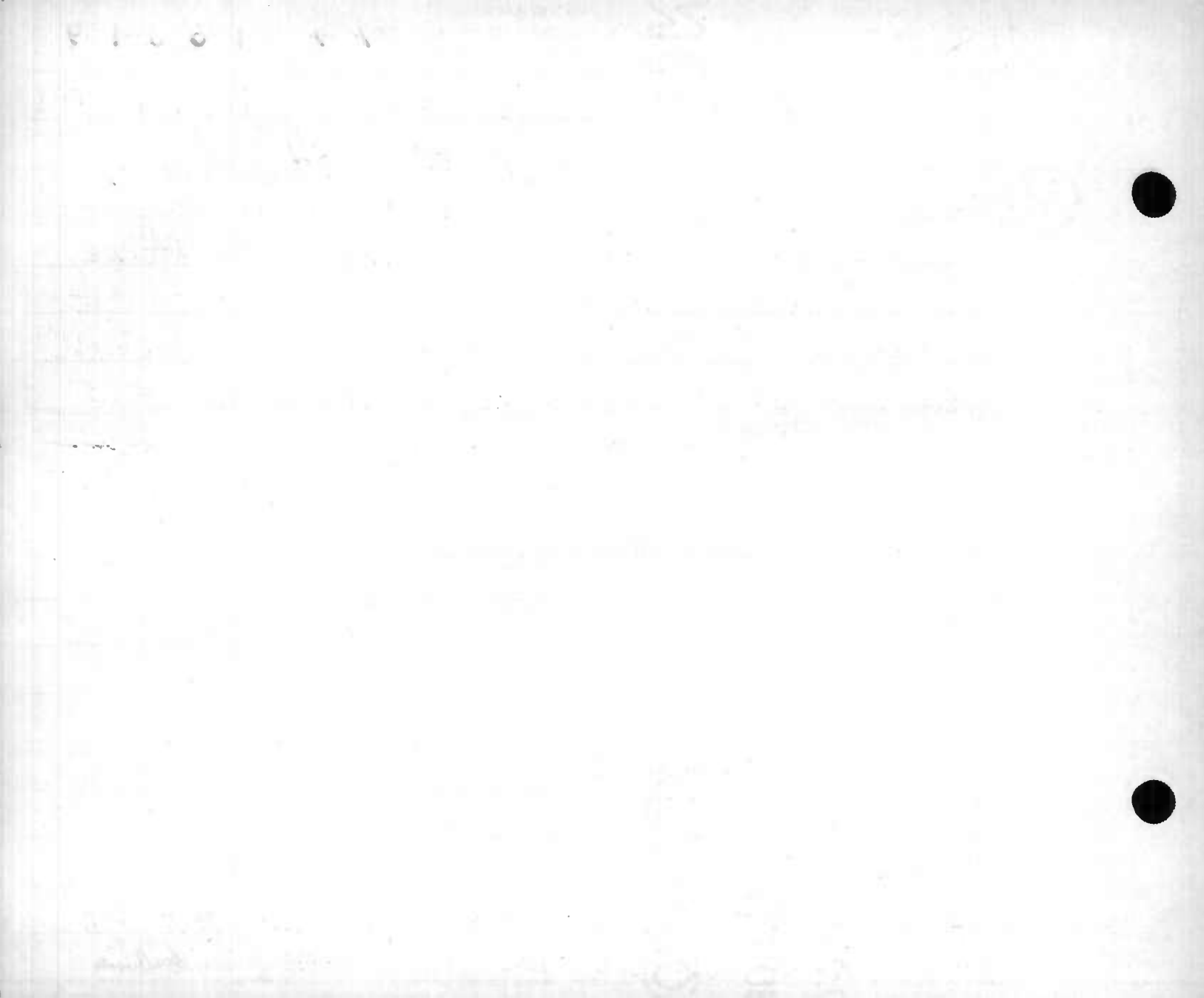
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

**(M)**

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR				7 9 16019				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Julian G. Gibbs Sr.				2a DATE OF DEATH 7/10/79				2b HOUR 11 PM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 1-20-95		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH DC.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County			
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a USUAL OCCUPATION (TYPE OR WORK FOR AGENCY OF WORKING LIFE) COIT SERVICE		12b KIND OF BUSINESS OR INDUSTRY ATTORNEY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MD				13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1400 Americana Drive	
14 FATHER'S NAME 14a FIRST THOMAS 14b MIDDLE 14c LAST GIBBS				15 MOTHER'S MAIDEN NAME 15a FIRST IDA 15b MIDDLE 15c LAST BURWELL					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO WWW		17 INFORMANT DEATH SANDBEN GIBBS		17 ADDRESS #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 3501 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Percutaneous Trigeminal Rhizotomy								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION July 9, 1979		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Trigeminal Neuralgia				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 79		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 7/6/79 to 7/11/79, that (I) (we) last saw the deceased alive on 7/10/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Jack Kushner				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7/14/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jack Kushner				22e ADDRESS 20 Ridgely Annapolis, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 7/14/79		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION CITY OR TOWN COUNTY STATE Mont. MD.			
24 FUNERAL DIRECTOR John M. Lykos				ADDRESS Annapolis, MD		25a DATE REC'D. BY REGISTRAR III 18 1979		25b REGISTRAR'S SIGNATURE Dorothy M. Brady	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 977-5338.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 6 0 2 0			
1. DECEASED NAME (TYPE OR PRINT) <b>THEODORA V. GIOVE</b>				2a. DATE OF DEATH MONTH <b>7</b> DAY <b>15</b> YEAR <b>1979</b> 2b. HOUR <b>2:38</b> M <b>M</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>8</b> YEAR <b>1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bari Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Annæ Arundel Co. MD</b>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Edgewater</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Ralph</b> MIDDLE <b></b> LAST <b>Vallone</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b></b> LAST <b>unknown</b>		13e. STREET ADDRESS <b>540 Londontown Rd.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>577-26-6903</b>		17. INFORMANT <b>Mary G. Seaton</b>		ADDRESS <b>1157 Carr Wharfs Rd. Edgewater Md. 21037</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture Cerebral Artery</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>430-</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b>				DUE TO, OR AS A CONSEQUENCE OF			
(c) <b></b>				DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Stroke prior MS.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-5</b> , 19 <b>79</b> , to <b>7-5</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7-5</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Paul A. Phillis</b> DEGREE <b></b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-6-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ERROL - A - Phillis</b>				22e. ADDRESS <b>20 Ridgely Ave. Anna Md 21404</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-9-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b></b> STATE <b>Md</b>	
24. FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home</b>		ADDRESS <b>12 Ridgely Ave. Ann. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>William McElroy</b>	

U.S. C. O. . . . .



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16021	
1. DECEASED NAME (TYPE OR PRINT) <b>F. L. Bby Marie</b>										2a. DATE OF DEATH KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI-MATED <input type="checkbox"/> <b>7 22 1979</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>1</b> YEAR <b>02</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	7. IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	2c. DATE PRONOUNCED DEAD <b>7 22 1979</b>		2d. HOUR <b>0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash, DC</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.				
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>shipping clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>retail sales</b>			
13a. STATE <b>Md</b>			13b. COUNTY <b>AACo</b>		13c. CITY OR TOWN <b>Edgewater</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Kussmull</b> LAST <b>Talbert</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mamie</b> MIDDLE <b>Talbert</b> LAST <b>Talbert</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>					
16b. SOCIAL SECURITY NO. <b>577 36 2912</b>			17. INFORMANT <b>Robert D. Glascoe; #13</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteroseptate D.D.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>F. L. Bby</b>			TITLE (SPECIFY) <b>M.D. Deputy</b>			DATE SIGNED <b>7. 22. 79</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>F. L. Bby</b>			ADDRESS <b>Annapolis, Md</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-25-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>PGCo</b> STATE <b>MD</b>				
24. FUNERAL DIRECTOR NAME <b>Robert D. Glascoe</b> ADDRESS <b>12 Ridgeley Ave - Annapolis, Md</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Robert D. Glascoe</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert Green</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 14, 1979</b>		2b. HOUR <b>6<sup>10</sup> P M</b>		
3. SEX <b>MALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 26 1946</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>32</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>203 Center St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY GREEN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINERVA TAYLOR</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-46-1407</b>		17. INFORMANT ADDRESS <b>CHARLOTTE GREEN 203 L Center St. Annapolis, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> <b>4354</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost b) <b>cardiomyopathy</b> c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>3 hr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<b>Refractory to Fallot</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/12</b> 19 <b>78</b> to <b>7/14</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7/14</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. Reese</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/15</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-19-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>			
24. FUNERAL DIRECTOR <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16023	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Clinton Paine GREER, Jr.										2a. DATE KNOWN OF DEATH ESTIMATED 7 24 1979	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2b. DATE PRONOUNCED DEAD 7 24 1979 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Linthicum				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 538 Cleveland Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computor Prog.		12b. KIND OF BUSINESS OR INDUSTRY Civil Serv.	
13a. STATE Maryland										13b. CITY OR TOWN Linthicum	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13d. STREET ADDRESS 538 Cleveland Road	
14. FATHER'S NAME FIRST MIDDLE LAST Clinton Paine Greer, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Persis R. (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W. II 215-10-5872		17. INFORMANT (wife) Mrs. Alberta E. Greer				ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Interosclerotic CVD</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that the cause of death described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>E. Linthard</i>				TITLE (SPECIFY) M.D. Deputy Medical Examiner				DATE SIGNED 7/24/79			
EXAMINER'S NAME (TYPE OR PRINT) E. Linthard				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 28, 1979		23c. NAME OF CEMETERY OR CREMATOR Y Druid Ridge Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto. Md.	
24. FUNERAL DIRECTOR NAME H. H. Hopkins						25a. DATE REC'D. BY REGISTRAR JUL 27 1979		25b. REGISTRAR'S SIGNATURE <i>L. H. Kelly</i>			
Singleton Funeral Home, Glen Burnie, Md.											



*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text and markings, possibly including a signature or date]*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6024	
1. DECEASED NAME (TYPE OR PRINT) <b>Edna J. Greek</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>7</b> DAY <b>24</b> YEAR <b>1979</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>1</b> YEAR <b>1909</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>69</b> YRS.	7. UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	8. UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	2c. DATE PRONOUNCED DEAD <b>7 24 1979</b>		2b. HOUR <b>7</b> AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Govt.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Treasurer Dept.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Deale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5946 Rockhold Creek Rd.</b>			
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>William</b> LAST <b>Padgett</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Lula</b> MIDDLE <b>G.</b> LAST <b>OLIFF</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>579-12-2413</b>		17. INFORMANT ADDRESS <b>Mary Lou Idle-Lee Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>intermediate CV's</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) <b>REPORTING</b> MEDICAL EXAMINER				DATE SIGNED <b>7. 24. 79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt</b>				ADDRESS <b>Annapolis Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-27-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>				23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>P.G.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Hardesty</b> ADDRESS <b>12 Ridgely Ave. Annapolis Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Anthony M. Green</b>			



P. 2001



*[Faint, illegible handwritten text covering the majority of the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DST

1. FOR STATE REGISTRAR		7 16025	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY BELLE HACKER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 18 1979</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24 1916</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.		10. CITY OR TOWN OF DEATH <b>GlenBurnie</b>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		13a. STREET ADDRESS <b>Rt. 1 Box 110 Lot 45 Bell's Mobile Park 21144</b>	
13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>A.A.Co. Severn</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry George Hildebrand</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anne Irene Kelly</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A 295-10-9172</b>	
17. INFORMANT <b>Husband</b>		ADDRESS <b>Mr. Roy Hacker Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC Arrest</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>massive MI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I (this hospital) attended the deceased from <b>7/18/79</b> to <b>7/18/79</b> , that I (we) saw the deceased alive on <b>7/18/79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.)			
22b. SIGNATURE <b>David A. Schwartz</b>		22c. DATE SIGNED <b>7/18/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David A. Schwartz</b>		22e. ADDRESS <b>325 Hospital Dr. #201 Glen Burnie, Md. 21061</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 23 1979</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Nichols Bethel Cem. Odenton</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>A.A.Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home Glen Burnie, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1979</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16026

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK</b>		JAMES <b>J.</b>		LAST <b>HADDAWAY</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 14 19 79</b>		2b. HOUR <b>2:25 a.m.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 19, 1960</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>18</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>		10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK) <b>Tire Mech.</b>		12b. KIND OF BUSINESS <b>Good Year</b>		13a. STATE <b>MD</b>		13b. COUNTY <b>AA</b>	
13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7916 Allard Ct. Apt 304</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas G. Haddaway</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Shirley M. Thomas</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>XXXXXXXXXX 217/86/5504</b>		17. INFORMANT <b>Mrs. Rebecca A. Haddaway (wife)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12:58AM 7 14 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>driver of auto lost control hit guard rail</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>highway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Ervin Highway 600ft. s. Anne Arundel Co., Md.</b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER <b>M.D. Assistant</b>		DATE SIGNED <b>7/15/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 17, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Pk.</b>	
23d. LOCATION CITY OR TOWN <b>Elkridge</b>		COUNTY <b>Howard</b>		STATE <b>MD</b>		24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1979</b>	

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 0 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IRENE V. HARRIED		2a. DATE OF DEATH MONTH DAY YEAR JULY 19, 1979		2b. HOUR 4:30 A.M.	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4-10-1928	
6 AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) A. A. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A. A. Co., Maryland			
10 CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10 Roosevelt Dr		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aid	
12b. KIND OF BUSINESS OR INDUSTRY Hospital		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b. CITY OR TOWN Annapolis	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 10 Roosevelt Dr.			
14 FATHER'S NAME FIRST MIDDLE LAST Eli Tongue		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Hopkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 215-28-2137		17. INFORMANT ADDRESS Thomas E. Harrried 10 Roosevelt Dr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anterior Septal Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2-3 hours</u> Approximate interval between onset and death: <u>2-3 hours</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from <u>7/19</u> 19 <u>79</u> , to <u>7/19</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7/19</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.					
22b. SIGNATURE R. I. Hochman, MD				22c. DATE SIGNED 7/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. I. Hochman, MD				22e. ADDRESS 16 Murray Ave, Annapolis, Md 21401	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/23/79		23c. NAME OF CEMETERY OR CREMATORY Chews Church	
23d. LOCATION CITY OR TOWN COUNTY STATE A. A. Co. Md		24. FUNERAL DIRECTOR NAME Charles E. Hicks		25a. DATE REC'D. BY REGISTRAR JUL 23 1979	
25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 0 2 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA M. HILL			2a. DATE OF DEATH MONTH DAY YEAR JULY 13, 1979		2b. HOUR DST 3:25 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec 29 1890		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GLEN BURNIE, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware			13b. COUNTY Sussex	13c. CITY OR TOWN Lewes	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Michael Dull			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 183 03 4164		17. INFORMANT ADDRESS William F. Hill same as 13 e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 6951 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Toxic Epidermal Necrolysis &amp; Cachexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Allergy IVP dye</u> DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe ASCVD; Carcinoma Bladder; RectoVaginal Fistula; 2° Radiation Ovarian Carcinoma; Renal Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1979</u> to <u>July 13, 1979</u> , that (I) (we) last saw the deceased alive on <u>12 July 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James D. Biles III</u>		DEGREE		22c. DATE SIGNED 13 July 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES D. BILES, III, M.D.		22e. ADDRESS 325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/16/79		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem	
23d. LOCATION CITY OR TOWN Baltimore		COUNTY BALTIMORE		STATE Md.	
24. FUNERAL DIRECTOR NAME George J. Gonce		ADDRESS Balto 21225 4001 Ritchie Hgwy		25a. DATE REC'D. BY REGISTRAR JUL 17 1979	
25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

D.S.T.

1. FOR STATE REGISTRAR		7 9 1 6 0 3 0	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST WILLIAM B. HILL		MONTH DAY YEAR JULY 24, 1979	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	MONTH DAY YEAR Aug. 27 1889	89 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		ANNE ARUNDEL COUNTY MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Electrician
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS	
Contractors		7738 Edgewood Rd. 21122	
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS	
		7738 Edgewood Rd. 21122	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST James H. Hill		FIRST MIDDLE LAST Sarah R. Reisinger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Yes		1915-19 579.28.5740	
17. INFORMANT		ADDRESS	
Anna M. Hill--Same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 436- } Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } COPD - ALTERED SCLE ROSIS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ COPD -			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 7/17/79, 19, to 7/24/79, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) I did not view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
Jorge B. Ramirez, M.D.		7/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Jorge B. Ramirez, M.D.		325 HOSPITAL DRIVE, SUITE 207 GLEN BURNIE, MARYLAND 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Cremation		7/25/1979	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Loudon Park		Baltimore Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Walter Brooks Bradley Inc. Balto., Md.		JUL 26 1979	
25b. REGISTRAR'S SIGNATURE			

20:2 4501 45 YR 6

1998

1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1603 D.S.T.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNIE LAURIE HOLMES</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 15, 1979</b>				2b. HOUR <b>1:45A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 5, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Orchard Bch</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>716 Hilltop Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert S. Heron</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Best</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Charles W. Holmes same as 13 e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive bilateral pneumonia</b> <b>5-86-</b> DUE TO, OR AS A CONSEQUENCE OF <b>aspiration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension coma</b> DUE TO, OR AS A CONSEQUENCE OF <b>dehydration</b> <b>Renal failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis with chronic brain synd.</b>											
19a. DATE OF OPERATION <b>NA</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>NA</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 9, 1979</b> to <b>July 15, 1979</b> , that (I) (we) last saw the deceased alive on <b>July 15, 1979</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>B. G. de Guzman, M.D.</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/15/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BENJAMIN A. DE GUZMAN, M.D.</b>				22e. ADDRESS <b>325 HOSPITAL DRIVE, SUITE 108 GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>				ADDRESS <b>4001 Ritchie Hwy</b>		24b. BALTO 21225		25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



10031  
JULY 1950

JULY 1950

ANNIE LAURIE HOLMES

ANNIE RUSSELL COUNTY

NORTH BRUNSWICK HOSPITAL

OLEN BURRIS

DR. J. W. BURRIS

BRUNSWICK COUNTY

BRUNSWICK COUNTY

325 HOSPITAL, N.Y.  
OLEN BURRIS, N.Y.

BENJAMIN A. DE GUZMAN, M.D.

BRUNSWICK

JULY 1950

BRUNSWICK

BRUNSWICK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles A. Hoover</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 30 79</b>			2b. HOUR <b>3P. M.</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 23, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>109 Ferndale Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Heating Tech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>109 Ferndale Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George S. Hoover</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel M. Pearson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>1949-1952 227-03-4019</b>		17. INFORMANT ADDRESS <b>Ethel H. Bowen, Covington, Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Pancreas</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (1) (this hospital) attended the deceased from <b>7/11/79</b> to <b>7/30/79</b> , that (1) (we) lost saw the deceased alive on <b>7/30</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.										
22a. SIGNATURE <b>R. Kirkley</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/30/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James S. Kirkley</b>			22e. ADDRESS <b>8726 E. E. Plummer Rd.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2 Aug. 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stevensonville, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History/Kirkley</b>		

BP

2620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 0 3 3  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <u>Gladys A Hopkins</u>		2a DATE OF DEATH MONTH DAY YEAR <u>7/1/79</u>		2b HOUR <u>3:am</u> M	
3 SEX <u>female</u>	4 RACE <u>white</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>3/25/1902</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>	7b CITIZEN OF WHAT COUNTRY? <u>USA</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>ANNE ARUNDEL</u> MD.	
10 CITY OR TOWN OF DEATH <u>Annapolis</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) <u>AGER. Hospt.</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b KIND OF BUSINESS OR INDUSTRY <u>HOME</u>
13a STATE <u>MD.</u>		13b COUNTY <u>AA</u>	13c CITY OR TOWN <u>ANAPOLIS</u>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <u>700 Bay Ridge Ave</u>
14 FATHER'S NAME FIRST MIDDLE LAST <u>WILFORD HARDESTY</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>WINDA WARD</u>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>	
16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>1-1</u>		17. INFORMANT <u>Virginia Quantie</u>		ADDRESS <u>17 Bear Hill Rd Groton, Conn</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Myocardial Infarction</u> <u>410-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>3-11</u> 19 <u>65</u> to <u>6-14</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-14</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>R.I. Hochman</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>7/2/79</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>R.I. Hochman</u>		22e ADDRESS <u>16 Murray Ave Annapolis, Md</u>			
23a BURIAL, CREMATION, REMOVAL (CHECK ONE) <u>BURIAL</u>	23b DATE <u>7/3/79</u>	23c NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>ANAPOLIS AA MD</u>	
24 FUNERAL DIRECTOR <u>John M. G. ...</u>		ADDRESS <u>... Annapolis, Md</u>		25a DATE REC'D. BY REGISTRAR <u>JUL 5 1979</u>	
				25b REGISTRAR'S SIGNATURE <u>...</u>	

10122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 3/72 25M  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

16034

1. DECEASED-NAME (Type or print) Elizabeth R Hudson			2a. DATE OF DEATH Month 7 Day 13 Year 79 2:05 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9/21/99	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (In years last birthday) 79 YRS.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7355 Furnace Branch Rd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. CITY OR TOWN Glen Bur		13c. STREET AND NUMBER 1819 Dorsey Rd.	
14. FATHER'S NAME Morris KXXXXX		15. MOTHER'S MAIDEN NAME Annie Day		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16b. SOCIAL SECURITY NO. 218-09-9534		17. INFORMANT Furnace Branch		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Failure 410- DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 min. 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1/2, 1978, to 7/13, 1979, that (I) (we) last saw the deceased alive on 6/19, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward O. Hunt Jr.		22c. DATE SIGNED 7/13/79		22d. PHYSICIAN'S NAME (Type) Edward O. Hunt Jr.	
22e. ADDRESS 2300 Garrison Blvd. Balto. Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/16/79	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Glen Burnie A.A. Md.		25a. RECORDING REGISTRY JUL 19 1979	
24. FUNERAL DIRECTOR Raymond C. Fink		25b. REGISTRY SIGNATURE [Signature]		25c. DATE	





BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A SUICIDE, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A HOMICIDE, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A NATURAL CAUSE, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A DISEASE, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A TRAUMA, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A POISONING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A SUFFOCATION, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A DROWNING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A BURNING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A FREEZING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A CRUSHING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A SQUEEZING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A CLIPPING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A SUFFOCATION, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A DROWNING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A BURNING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A FREEZING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A CRUSHING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A SQUEEZING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED TO BE A CLIPPING, THE CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16035	
1. DECEASED NAME (TYPE OR PRINT) <i>Joseph H. Humphreys</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>7 9 1979</i>		2b. HOUR <i>A</i>			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 20 13</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>66</i> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <i>7 9 1979</i>		2d. HOUR <i>A</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.					
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North. ARUNDEL HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>INSPECTOR - Roads</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>COUNTY</i>			
13a. STATE <i>MD</i>						13b. COUNTY <i>ANNE ARUNDEL</i>		13c. CITY OR TOWN <i>PASADENA</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH NEAL HUMPHREYS</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LENOIR LUTHER</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>218-05-9415</i>		17. INFORMANT <i>MILDRED HUMPHREYS - SAME</i>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Artery Artery Occlusion</i> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Sudden</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>E. L. L. H. H.</i>				TITLE (SPECIFY) <i>M.D. Deputy</i>				DATE SIGNED <i>7-9-79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>E. L. L. H. H.</i>				ADDRESS <i>San Gabriel, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>7/13/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN</i>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>GLEN BURNIE MD</i>					
24. FUNERAL DIRECTOR NAME <i>McCULLY FUN. HOME</i> ADDRESS <i>130 E. FORT AVE</i>						25a. DATE REC'D. BY REGISTRAR <i>JUL 12 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>			

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DST

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM S. pedden HUNT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 24, 1979</b>			2b. HOUR <b>7:57A M.</b>			
1. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 21, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Warehouse</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD.</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 305 B, 205th St. Pas. Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Morris Hunt</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate Knipp</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES) <b>-----</b>		16b. SOCIAL SECURITY NO. <b>216-01-4025</b>		17. INFORMANT ADDRESS <b>Helen R. Hunt same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Acute Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCUR</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/21</b> 19 <b>77</b> , to <b>7/21</b> 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>7/21</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GLENN F. ROBBINS, M.D.</b>						22e. ADDRESS <b>1404 CRAIN HIGHWAY, SUITE 300 GLEN BURNIE, MARYLAND 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 28, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Pk. Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>McCully F.H. Mountain &amp; Tick Neck Rds. Pas. Md.</b> ADDRESS <b>21122</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.



RECEIVED  
JUL 21 1934



TO HOSPITALS AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR				7 9 1 6 0 3 7					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
Elizabeth Hunter				7 31 79				11 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		5 8 93		86		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Scotland		U.S.A.				Anne Arundel MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Millersville		Knollwood Manor				Housewife		At home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Virginia				Arlington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1500 S. Fern St. #912	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
James Horne				Agnes Morris					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT			
No				577-05-6627		John Hunter 1500 S. Fern St. #912 Arlington, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Penumonia DUE TO, OR AS A CONSEQUENCE OF (c) 486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Senile Dementia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 1, 19 79, to July 31, 19 79, that (I) (we) lost saw the deceased alive on July 30, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
Paul S. Rhodes, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				7/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Paul S. Rhodes, M.D.				1667 Crofton Center, Crofton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		8/3/79		Cedar Hill Cemetery		Sutland Prince George Md.			
24. FUNERAL DIRECTOR				24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
George P. Kalas Funeral Home				6160 Oxon Hill Rd. Oxon Hill, Md.		AUG 3 1979			

BP

10001-21





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 6 0 3 3 REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) JAMES EDWARD HUTCHINS					2a. DATE OF DEATH MONTH DAY YEAR JULY 12, 1979			2b. HOUR 11:20 <sup>AM</sup>	
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 19 32		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 327 Chalet Dr.		
13a. STATE Md.		13b. COUNTY H.A.		13c. CITY OR TOWN Balto.					
14 FATHER'S NAME FIRST MIDDLE LAST Percy Boardley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Hutchins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17 INFORMANT Benice Hutchins		ADDRESS 327 Chalet Dr.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Renal Adenocarcinoma</u> 1890 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>past two years</u> to _____, 19____, that (I) (we) last saw the deceased alive on <u>July 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James D. Biles III</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 13 July 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES D. BILES, III, M.D.				22e. ADDRESS 325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/17/79		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md.			
24 FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 17 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>	

MEDICAL CERTIFICATION



3 0 0 3 3

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

10

No.		Date		Time		Place		Remarks	
1		1917		10:30		New York		Arrived at New York	
2		1917		11:00		New York		Left New York	
3		1917		11:30		New York		Arrived at New York	
4		1917		12:00		New York		Left New York	
5		1917		12:30		New York		Arrived at New York	
6		1917		13:00		New York		Left New York	
7		1917		13:30		New York		Arrived at New York	
8		1917		14:00		New York		Left New York	
9		1917		14:30		New York		Arrived at New York	
10		1917		15:00		New York		Left New York	
11		1917		15:30		New York		Arrived at New York	
12		1917		16:00		New York		Left New York	
13		1917		16:30		New York		Arrived at New York	
14		1917		17:00		New York		Left New York	
15		1917		17:30		New York		Arrived at New York	
16		1917		18:00		New York		Left New York	
17		1917		18:30		New York		Arrived at New York	
18		1917		19:00		New York		Left New York	
19		1917		19:30		New York		Arrived at New York	
20		1917		20:00		New York		Left New York	
21		1917		20:30		New York		Arrived at New York	
22		1917		21:00		New York		Left New York	
23		1917		21:30		New York		Arrived at New York	
24		1917		22:00		New York		Left New York	
25		1917		22:30		New York		Arrived at New York	
26		1917		23:00		New York		Left New York	
27		1917		23:30		New York		Arrived at New York	
28		1917		24:00		New York		Left New York	
29		1917		24:30		New York		Arrived at New York	
30		1917		25:00		New York		Left New York	
31		1917		25:30		New York		Arrived at New York	
32		1917		26:00		New York		Left New York	
33		1917		26:30		New York		Arrived at New York	
34		1917		27:00		New York		Left New York	
35		1917		27:30		New York		Arrived at New York	
36		1917		28:00		New York		Left New York	
37		1917		28:30		New York		Arrived at New York	
38		1917		29:00		New York		Left New York	
39		1917		29:30		New York		Arrived at New York	
40		1917		30:00		New York		Left New York	
41		1917		30:30		New York		Arrived at New York	
42		1917		31:00		New York		Left New York	
43		1917		31:30		New York		Arrived at New York	
44		1917		32:00		New York		Left New York	
45		1917		32:30		New York		Arrived at New York	
46		1917		33:00		New York		Left New York	
47		1917		33:30		New York		Arrived at New York	
48		1917		34:00		New York		Left New York	
49		1917		34:30		New York		Arrived at New York	
50		1917		35:00		New York		Left New York	
51		1917		35:30		New York		Arrived at New York	
52		1917		36:00		New York		Left New York	
53		1917		36:30		New York		Arrived at New York	
54		1917		37:00		New York		Left New York	
55		1917		37:30		New York		Arrived at New York	
56		1917		38:00		New York		Left New York	
57		1917		38:30		New York		Arrived at New York	
58		1917		39:00		New York		Left New York	
59		1917		39:30		New York		Arrived at New York	
60		1917		40:00		New York		Left New York	
61		1917		40:30		New York		Arrived at New York	
62		1917		41:00		New York		Left New York	
63		1917		41:30		New York		Arrived at New York	
64		1917		42:00		New York		Left New York	
65		1917		42:30		New York		Arrived at New York	
66		1917		43:00		New York		Left New York	
67		1917		43:30		New York		Arrived at New York	
68		1917		44:00		New York		Left New York	
69		1917		44:30		New York		Arrived at New York	
70		1917		45:00		New York		Left New York	
71		1917		45:30		New York		Arrived at New York	
72		1917		46:00		New York		Left New York	
73		1917		46:30		New York		Arrived at New York	
74		1917		47:00		New York		Left New York	
75		1917		47:30		New York		Arrived at New York	
76		1917		48:00		New York		Left New York	
77		1917		48:30		New York		Arrived at New York	
78		1917		49:00		New York		Left New York	
79		1917		49:30		New York		Arrived at New York	
80		1917		50:00		New York		Left New York	
81		1917		50:30		New York		Arrived at New York	
82		1917		51:00		New York		Left New York	
83		1917		51:30		New York		Arrived at New York	
84		1917		52:00		New York		Left New York	
85		1917		52:30		New York		Arrived at New York	
86		1917		53:00		New York		Left New York	
87		1917		53:30		New York		Arrived at New York	
88		1917		54:00		New York		Left New York	
89		1917		54:30		New York		Arrived at New York	
90		1917		55:00		New York		Left New York	
91		1917		55:30		New York		Arrived at New York	
92		1917		56:00		New York		Left New York	
93		1917		56:30		New York		Arrived at New York	
94		1917		57:00		New York		Left New York	
95		1917		57:30		New York		Arrived at New York	
96		1917		58:00		New York		Left New York	
97		1917		58:30		New York		Arrived at New York	
98		1917		59:00		New York		Left New York	
99		1917		59:30		New York		Arrived at New York	
100		1917		60:00		New York		Left New York	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 6 0 3 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret H. Insley</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>7-16-79</i>			2b. HOUR <i>11:58 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9-7-98</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.				
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOTHING IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel Gen. Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>					13b. COUNTY <i>P.A.</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alice Snyder</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-44-7361</i>		17. INFORMANT ADDRESS <i>Howard Insley - Sec. 13</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>436-</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) the <del>physician</del> attended the deceased from <i>12-26</i> , 19 <i>61</i> , to <i>7/16</i> , 19 <i>79</i> , that (I) <del>last</del> saw the deceased alive on <i>7/16</i> , 19 <i>79</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> (did not) view the body after death.										
22b. SIGNATURE <i>R.I. Harriman, MD</i>						DEGREE		22c. DATE SIGNED <i>7/17/79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. I. Harriman, MD</i>						22e. ADDRESS <i>16 Murray Ave, Annapolis, Md 21401</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>7-20-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore MD</i>			
24. FUNERAL DIRECTOR NAME <i>Robert S. Barranco</i>			25a. DATE RECEIVED BY REGISTRAR <i>JUL 23 1979</i>							

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79 16040				DST			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THELMA VIRGINIA ISAAC</b>								2a. DATE OF DEATH MONTH DAY YEAR <b>July 26, 1979</b>				2b. HOUR <b>7:30 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 25, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>71</b>		8. IF UNDER 1 YEAR MONTHS DAYS <b>71</b>		9. IF UNDER 24 HRS. HOURS MIN. <b>71</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Telephone Solicitor (Charity)</b>					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Solicitor (Charity)</b>				12c. ADDRESS <b>Glen Burnie, Md. 21061</b>					
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box 188 Francis Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Mulligan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Thornhill</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>217-09-0285</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>217-09-0285</b>				17. INFORMANT ADDRESS <b>Glen Burnie, Maryland 21061</b> <b>Mr. Joseph E. Isaac Rt. 1 Box 188 Francis Rd</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Acute Myocardial Infarction - Pulmonary emboli</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/25/79 19</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/25/79 19</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) this hospital attended the deceased from <b>7/25/79</b> 19 to <b>7/26/79</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) view the body after death.			
22a. SIGNATURE <b>Jorge B. Ramirez</b>		22b. DEGREE <b>MD</b>		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>7/26/79</b>		22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JORGE B. RAMIREZ, MD.</b>		22f. ADDRESS <b>325 Hospital Drive, #207</b> <b>Glen Burnie, Maryland, 21061</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 30, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Anne Arundel Md.</b>		24. FUNERAL DIRECTOR NAME <b>Mc Cully Funeral Home of Brooklyn</b>		24b. ADDRESS <b>237 E. Patapsco Avenue Balto., Md. 21225</b>		25a. DATE REC'D. BY REGISTRAR <b>III 27 1979</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 7 9 1 6 0 4 1							
1. DECEASED NAME (TYPE OR PRINT) <i>Ruth Elizabeth Itter</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>7-14-79</i>				2b. HOUR <i>2:35 A M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5-18-27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County, MD.</i>			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Anne Arundel</i> 13c. CITY OR TOWN <i>Pasadena</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2004 Poplar Ridge Rd. 21122</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frederick Joh</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ruth Elizabeth Meeth</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-20-3037</i>		17. INFORMANT <i>John A. Itter</i>		ADDRESS <i>Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Inflammatory Lung Disease</i> <i>2041</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7/13</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. Bienn E. Cole</i> DEGREE								22c. DATE SIGNED <i>7/14</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Bienn</i>				22e. ADDRESS <i>A.A. General Hospital, Annapolis, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/17/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Meth. Ch. Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Pasadena, Anne Arundel, Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Mc Cully F.H. Mtn. &amp; Tick Neck Rds., Pasadena, Md. 21122</i>				25. DATE REC'D. BY REGISTRAR <i>JUL 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

1906



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 9 16042								
1. DECEASED NAME (TYPE OR PRINT)		FIRST Broderick A. L.		MIDDLE Jackson		LAST Jackson		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 11 75		6. AGE (IN YEARS LAST BIRTHDAY) 4 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ROBINS WARNER 31093 ROBINS ROBINS, GA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH FEGGM MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FEGGM KAH, MD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA		12b. KIND OF BUSINESS OR INDUSTRY NA		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY A. A.		13c. CITY OR TOWN FEGGM		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7205 "C" Eubanks Loop FEGGM
14. FATHER'S NAME FIRST MIDDLE LAST Alvin P Jackson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE JANNETTE WRIGHT								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT ALVIN P. JACKSON		ADDRESS 7205 "C" EUBANKS LOOP FEGGM				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest 2089 DUE TO, OR AS A CONSEQUENCE OF (b) Leukemia - T cell DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jean C. Smith		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-28-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jean C. Smith		22e. ADDRESS KAH / FEGGM, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/1/79		23c. NAME OF CEMETERY OR CREMATORY MAGNOLIA CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BONABRE		25a. DATE RECEIVED BY REGISTRAR JUL 30 1979		
24. FUNERAL DIRECTOR E. BARNES FLEMING FUNERAL SERVICE		ADDRESS BENSON, MD.		25b. SIGNATURE [Signature]						

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A13 ME (5))  
15M 7/76

Items #18a-22a Film G534 8/29/79 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16043	
1. DECEASED NAME (TYPE OR PRINT) <b>John Johnson</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>7</b> DAY <b>30</b> YEAR <b>1979</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>20</b> YEAR <b>1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD</b>		2c. DATE PRONOUNCED DEAD <b>7 30 1979</b>		2d. HOUR <b>11:35 A</b>	
10. CITY OR TOWN OF DEATH <b>Crownsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crownsville State Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Crownsville, Md.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Crownsville, Md.</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Edward</b> LAST <b>Johnson</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b>Jane</b> LAST <b>Evans</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Annie Johnson</b> ADDRESS <b>418 Capital Heights Bldg. Capital Heights, Md. 21027</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Drowning</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>9104</b>											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. <b>9</b> MONTH <b>7</b> DAY <b>30</b> YEAR <b>1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>drowned in bathtub</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hospital</b>		21f. LOCATION CITY OR TOWN <b>Crownsville</b> COUNTY <b>A.A.</b> STATE <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>7/31/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/4/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Carmel Burial</b>		23d. LOCATION CITY OR TOWN <b>Burial</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>William Reese &amp; Son Mortuary, P.A.</b> ADDRESS <b>Annapolis, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 02 1979</b>		25b. REGISTRAR'S SIGNATURE 					

Almanac

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 16044		DST		
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN T. JOHNSON					2a. DATE OF DEATH - MONTH DAY YEAR 7 21 1979			2b. HOUR P M 9:50 P M	
3. SEX Male			4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 8 1893			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 85 YRS.			IF UNDER 1 YEAR HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.						
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. CITY OR TOWN A. A. CO.		13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7869 Levy Ct.				
14. FATHER'S NAME FIRST MIDDLE LAST John T. Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Richardson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 05 9367		17. INFORMANT ADDRESS Ellen Cager 7869 Levy Ct. 21122									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Death 20 to</i> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>SCUT</i> (c) <i>SCUT</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Coronary Heart Failure 20 Cor. Insufficiency</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>7/10/79</i> to <i>7/21/79</i> , that (I) (we) lost <i>7/21/79</i> saw the deceased alive on <i>7/21/79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)														
22b. SIGNATURE <i>Anastacio E. Subong</i>			DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/22/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anastacio E. Subong, M.D.					22e. ADDRESS 1406 Grain Hwy. S., #102 Glen Burnie, Md. 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-26-79		23c. NAME OF CEMETERY OR CREMATORY Magothy Church Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Magothy A. A. CO. Md.						
24. FUNERAL DIRECTOR NAME Isaiah L. Brown & Son PA 1913 W. Baltimore					25a. DATE REC'D. BY REGISTRAR JUL 23 1979			25b. REGISTRAR'S SIGNATURE <i>Isaiah L. Brown</i>						

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12

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

16045

REG. NO.

DST

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM Lawrence JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 7 21 1979			2b. HOUR P M 4:10 P M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 28 09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.						
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgr.			12b. KIND OF BUSINESS OR INDUSTRY Serv. Sta.			
13a. STATE Md			13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1065 Bell Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST William T. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Lambertson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frances E. Johnson (wife)			Same as 13				
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>4/4/79</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Ca 2 prostate; Previous myocardial infarct</u>												
19a. DATE OF OPERATION 7-20			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED incisional hernia			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>7-21-79</u> to <u>7-21-79</u> , that (I) (we) lost <u>saw the deceased alive on above</u> , (I) (we) (did) (did not) view the body after death. <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated												
22b. SIGNATURE <u>[Signature]</u>						DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ernesto A. Tolentino, M.D.						22e. ADDRESS 325 Hospital Dr. #204 Glen Burnie, Md. 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 25, 79		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA Md.				
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md.						25a. DATE REC'D. BY REGISTRAR JUL 24 1979			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 6 0 4 6			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CARL Bailey Jones</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7-6-79</b>			2b. HOUR <b>2:48</b> M
3 SEX <b>MALE</b>	4 RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-28-1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Brooklyn NY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A. Co Maryland MD</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, CITY STREET ADDRESS) <b>1106 Brashears St.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NAVAL</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Solomon Jones</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Jones</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>124-03-0825</b>		17. INFORMANT ADDRESS <b>MRS Nancy Jones 1106 Brashears</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4+ months</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/1/79</b> , 19 <b>79</b> , to <b>Alone</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>7/1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. R.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/8</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Bhein</b>				22e. ADDRESS <b>121 Cathedral Street</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/10/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn Cemet.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>A.A. Co. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Charles E. Hicko III</b>				ADDRESS <b>1922 Forest Dr</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>			



Male  
George W. Jones  
1106 S. 1st St.  
St. Louis, Mo.  
James H. Jones  
1106 S. 1st St.  
St. Louis, Mo.  
James H. Jones  
1106 S. 1st St.  
St. Louis, Mo.

Robert Jones  
1106 S. 1st St.  
St. Louis, Mo.  
James H. Jones  
1106 S. 1st St.  
St. Louis, Mo.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16047	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Craig Allen Jones</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR HOUR <b>7 28 19 79</b>	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 24 1953</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>25 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>7 28 19 79</b>	7d. HOUR <b>6:26 P.</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>			MD.		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Personnel Spec't</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Virginia</b>		13b. COUNTY <b>Fairfax</b>		13c. CITY OR TOWN <b>Springfield</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8712 Clydesdale Road 22151</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul G Jones</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Robertra Halgert</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>223 82 9330</b>		17. INFORMANT ADDRESS <b>Wife, same as deceased</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Electrocution and drowning</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>9258</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:55 P.M. 7/28/ 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>while swimming in water</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Marina</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 261 Harrington Marina Rose Haven A.A. Co. Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>J.R. Swan</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>7/30/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>8/1/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairfax Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fairfax, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Halden Smith</b>				ADDRESS <b>Demaine Funeral Home, Alexandria, Va 22314</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1979</b>		25b. REGISTRAR SIGNATURE <b>Robert M. Brady</b>	

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(VR A15 ME (5))  
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TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 20M  
(VRA 15, 4) 7/78

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR						DEPARTMENT OF HEALTH AND MENTAL HYGIENE						79 16048					
I. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR					
FIRST MIDDLE LAST																	
3 SEX						4 RACE						5. DATE OF BIRTH MONTH DAY YEAR					
male						white						2-28-10					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS					
Conn						USA						69 YRS MONTHS DAYS HOURS MIN.					
11 CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Annapolis						Anne Arundel General Hosp						RELIGION					
13a. STATE						13b. COUNTY						13c. CITY OR TOWN					
MD						Anne Arundel Annapolis						3 Murray Ave					
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						13d. INSIDE CITY LIMITS? YES NO					
ALBERT COREY JONES						LATHERINE CHESBRO						YES NO					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO						17 INFORMANT ADDRESS					
NO						019-30-7538						ADAHINE MOSS JONES #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.)												APPROXIMATE TIME BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Rheumatic heart disease																	
398- DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
diabetes mellitus s/p pericarditis																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES NO				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO					
								YES NO				YES NO					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
				19													
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 19__ to __-__-19__, that (we) lost saw the deceased alive on __-__-19__, and that in my opinion death occurred on the date and hour and from the causes stated above; (If we did not view the body after death, so state.)																	
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN																	
GA Mitchell MD 7-16-79																	
22c. DATE SIGNED																	
7-16-79																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS																	
Gregory A. Mitchell MD 1606 Forest Dr. Annapolis Md																	
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN STATE					
CREMATION				7/17/79				Ft. Lincoln				BRENTWOOD PG. MD					
24a. FUNERAL DIRECTOR 24b. DATE REC'D. BY REGISTRAR 24c. REGISTRAR'S SIGNATURE																	
John M. Lyrras Annapolis md JUL 18 1979 history McCreedy																	

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(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGES 6 AND 7 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Philip Harold Katcef								July 7 1979								A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	Jan 29, 1919		60		YRS.				July 7, 1979						A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		X		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
Md		USA		WIDOWED		DIVORCED				AX Co							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Annapolis		1634 Holly Beach Farm Rd.		Retail sales		Liquor											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		AA Co		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1634 Holly Beach Farm Rd.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
William M. Katcef		Annie Zavada															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
yes		WW 2		213-12-2640		Benjamin H. Katcef		Annapolis, Md. 21401									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound skull</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. 9554		(b)		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7 7 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Self-inflicted gun shot wound</u>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input checked="" type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhart</u>		TITLE (SPECIFY) M.D. <u>Depo 49</u>		MEDICAL EXAMINER		DATE SIGNED <u>7-7-79</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>E. Linhart</u>		ADDRESS <u>Annapolis, Md</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		7-8-79		Kneseth Israel		Annapolis		AA Co. Md									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. DATE OF DEATH											
Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401				JUL 11 1979													

9 2 0 0 1 9 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

DST

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

KATHERINE (NMN)

KEENE

2a. DATE OF DEATH

MONTH

DAY

YEAR

JULY 21, 1979

2b. HOUR

7:00

A  
M

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

MONTH

DAY

YEAR

8 15 93

6. AGE (IN YEARS LAST BIRTHDAY)

85

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A

8

MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

ANNE ARUNDEL COUNTY

MD.

10. CITY OR TOWN OF DEATH

GLEN BURNIE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

NORTH ARUNDEL HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

A.A.CO

13c. CITY OR TOWN

ODENTON

13d. INSIDE CITY LIMITS?

YES ☐NO ☒

13e. STREET ADDRESS

MARYLAND TRAILER CT, ODENTON

21113

14. FATHER'S NAME

Wiley

MIDDLE

Justus

LAST

15. MOTHER'S MAIDEN NAME

Sally

MIDDLE

May

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

213-24-874D

17. INFORMANT

ADDRESS

Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIO-RESPIRATORY FAILURE

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 hr

436-  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

CEREBRO VASCULAR ACCIDENT

6 weeks

DUE TO, OR AS A CONSEQUENCE OF

(c)

PERIPHERAL EMBOLISATION

3 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

CORONARY ARTERY DISEASE

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

No

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

No

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED

Not Applicable.

21d. INJURY OCCURRED

WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-5, 1979, to 7-21, 1979, that (I) (we) last  
saw the deceased alive on 7-20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE

Niranjan P. Sharma

DEGREE

M.D.

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

7/21/79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

NIRANJAN P. SHARMA, M.D.

22e. ADDRESS

1113 OLD ODENTON RD.  
ODENTON, MARYLAND 2111323a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

24 July 79

23c. NAME OF CEMETERY OR CREMATORY

Baker Family Cem. Hurley, Buchanan, Va.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

James S. Kirkley, Glen Burnie, Md.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

JUL 24 1979

25b. REGISTRAR'S SIGNATURE

J. S. Kirkley

10000

JULY 21, 1972

KATHERINE (WIFE)

Female (Chronic) 3 1/2

State of Tennessee

North Andrew Hospital

X

1972

July

1972

1972

Medical Records

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 6 0 5 1			
1. FOR STATE REGISTRAR				2e. DATE OF DEATH MONTH DAY YEAR 7-31-79			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE J. KELLEY JR.				2b. HOUR 9:10 M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11-29-21		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL County MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Col. U.S.A.F. Military		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY A.A. Arnold		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George J. Kelly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Mae Gladden		16. STREET ADDRESS 1605 Chocataw Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) Yes 1941-1947		16b. SOCIAL SECURITY NO. 226-18-431		17. INFORMANT ADDRESS Elma Kuchar Kelley #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypernephroma</u> - 1890							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/79, 19, to 7/31/79, 19, that (I) <del>was</del> last saw the deceased alive on 7/30/79, 19, and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)							
22b. SIGNATURE Stanley P. Watkins M.D.				22c. DATE SIGNED 7/31/79		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley P. Watkins				22f. ADDRESS 121 CATHEDRAL ST. ANNAPOLIS MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/2/79		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Annapolis VA.	
24. FUNERAL DIRECTOR NAME John M. Taylor & Sons				24b. ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR AUG 15 1979	
25b. REGISTRAR'S SIGNATURE							

1 0 0 0 1

95-8-5



1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH16052  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles C Kim</b>			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> <b>7 22 1979</b>			2b. HOUR <b>6:15 a.m.</b>		
3. SEX <b>male</b>	4. RACE <b>Oriental</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 3, 1927</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>7 22 1979</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kaeseng, Korea</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>National Academy of Sciences</b>		
13a. STATE <b>Md</b>		13b. COUNTY <b>PG</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>16201 Penn Manor Lane</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sangbok Kim</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>224 68 0432</b>		17. INFORMANT ADDRESS <b>Wanda W. Kim # 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Visceral and skeletal Injuries</b> 8150 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:14 a.m. 7/22 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of automobile fixed object collision</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 214, West of Queen Anne Bridge, AACo. MD</b>				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>		M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>7/23/79</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan</b>		ADDRESS <b>111 Penn Street, Balto. MD 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-25-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Annes</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AACo Md</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hardesty PH, 12 Ridgely Ave, Annapolis, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>		



10022



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 6 0 5 3

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH KNEPPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 17 1979</b>			2b. HOUR <b>1:40</b> M			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 3 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BAY MANOR NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>SEVERN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 73 MONARD AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS KNEPPER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>AUGUSTA SCHLERL</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-03-1840</b>		17. INFORMANT ADDRESS <b>Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Blind, Deaf</b>									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>NO injury</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/30/75</b> , 19 <b>75</b> , to <b>7/17/79</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7/17/79</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b> DEGREE				22c. DATE SIGNED <b>7/17/79</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.H. Wirth MD</b>				22e. ADDRESS <b>Lothian Md 20820</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>21 July 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 0 5 4

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>George H. Koolage</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>July 31 79</b>	
3. SEX <b>M</b>		2b. HOUR <b>10:15 PM</b>	
4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 10, 1919</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Anne Arundel General</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Executive</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Savings &amp; Loan</b>	
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Annapolis</b>	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>98 Duke of Gloucester St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry N. Koolage</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Carmean</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES) <b>66RA-219-05-1083</b>	
17. INFORMANT <b>Harry N. Koolage</b>		ADDRESS <b>1170 Cavalier Rd. Arnold, Md. 21012</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UGT Hemorrhage -</b> <b>5715</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>fatal embolism - displaced nodule.</b> DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION <b>July 31 79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If warranted, I did not view the body after death.)			
22b. SIGNATURE <b>Stephen B. Hiltabiddle</b>		22c. DATE SIGNED <b>July 31 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen B. Hiltabiddle</b>		22e. ADDRESS <b>801 Melvin Ave Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/3/79</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Anne's Cemetery Annapolis, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S NAME <b>John M. Taylor &amp; Sons Annapolis, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>AUG 3 1979</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 16055	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR				
		Ruth NMN Lattuca		2. SEX Female		3. RACE White		4. DATE OF BIRTH MONTH DAY YEAR		5. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.	
		Maryland		6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
		Ft. Meade		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
		Maryland		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		James Wheeler		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-46-3572	
		Anne Arundel		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
		Gambrells		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		4140		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
		4140		22a. I certify that (I) (this hospital) attended the deceased from 2 July 19 77, to 21 July 19 77, that (I) (we) last saw the deceased alive on 21 July 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE E. Zeidman		22c. DATE SIGNED 21 July 78		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Zeidman	
		4140		22e. ADDRESS Kimbrough Army Hospital		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 25 JUL '79		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	
		4140		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		23g. REGISTRAR'S SIGNATURE	
		4140		23h. REGISTRAR'S SIGNATURE		23i. REGISTRAR'S SIGNATURE		23j. REGISTRAR'S SIGNATURE		23k. REGISTRAR'S SIGNATURE	
		4140		23l. REGISTRAR'S SIGNATURE		23m. REGISTRAR'S SIGNATURE		23n. REGISTRAR'S SIGNATURE		23o. REGISTRAR'S SIGNATURE	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

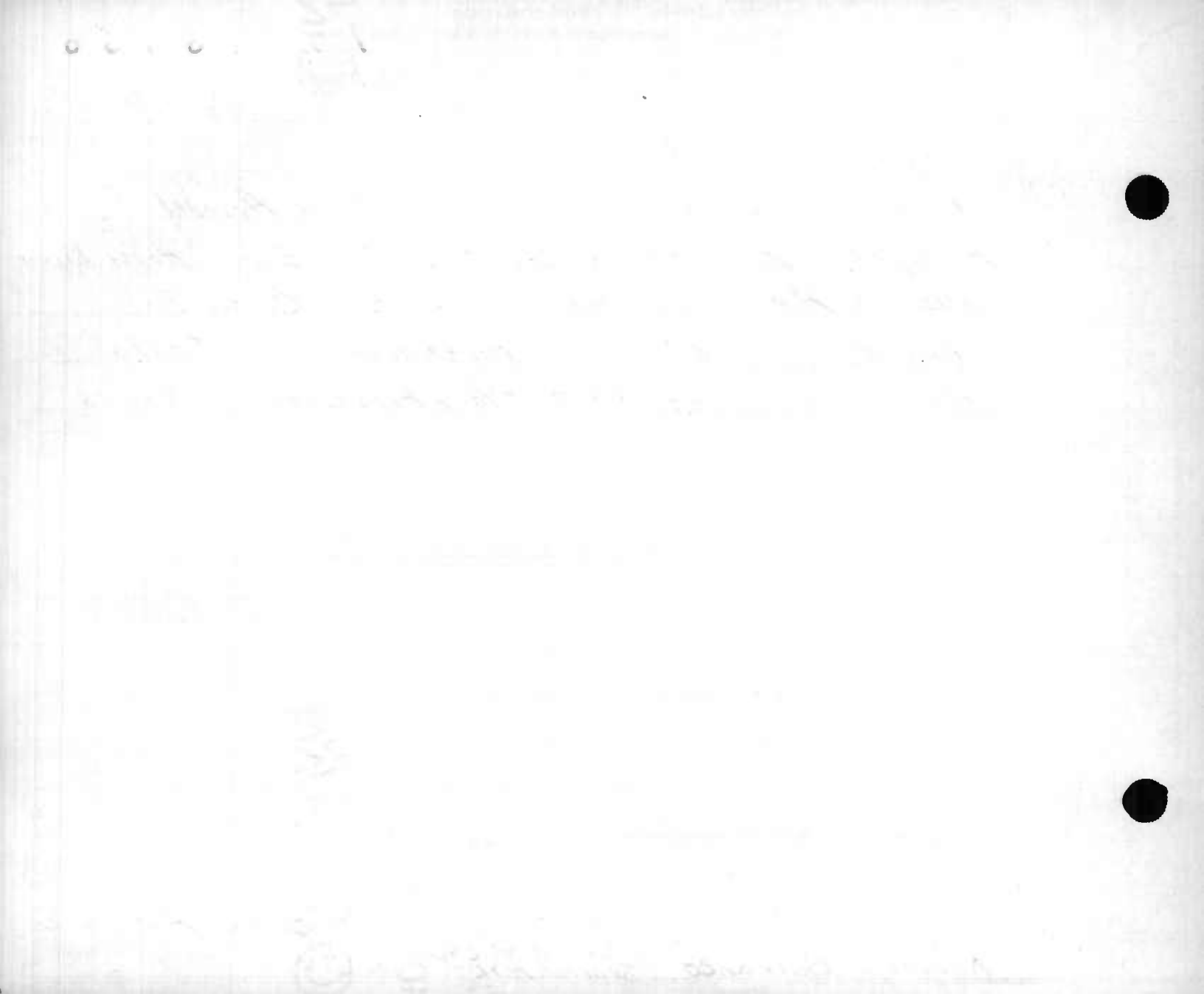
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 16056	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Louis J LAZZARO						7-10-79			2:00 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		White		7 21 04			74 YRS				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.					Anne Arundel MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel Gen. Hosp.			Self Emp.			House Repair		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS		
MD.			A.A.			Severna Park			590 Center Dr.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Frank Lazzaro			Raffaella Scala								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS					
No			216-34-3341			Mary Anne Lazzaro - Sec 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>complication of metastatic cat uveitis</u> (c) <u>cell carcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 19 <u>79</u> , to <u>July 16</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>July 16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James Ross</u> M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>7-10-79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS <u>20 Rikely Ave, Annapolis Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			7-13-79		Glen Haven Cem.		Glen Burnie A.A. MD.				
24. FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert S. Barranco						501 Rikely Ave Severna Park		JUL 13 1979		Henry McBrady	

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16057	
1. DECEASED NAME (TYPE OR PRINT) <b>AMY Kay Lee</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>7/9/79</b>		2b. HOUR <b>8:45</b>		2c. DATE PRONOUNCED DEAD <b>7/9/79</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>4/24/79</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>2 YRS. 2 MONTHS 15 DAYS</b>		7. IF UNDER 1 YR. <b>2 MONTHS 15 DAYS</b>		7. IF UNDER 24 HRS. <b>2 MONTHS 15 DAYS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Infant</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>Glen Burnie</b>		13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME <b>Mang Yan Lee</b>						15. MOTHER'S MAIDEN NAME <b>Karen Jenkins</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Diane Shaw A.A. Co. Social Service</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ChickenPox with complications</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>052-</b> (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Hormez R. Guard</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>7/9/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/11/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>Balto 21225</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Elizabeth FOGLE LEE			2a. DATE OF DEATH MONTH DAY YEAR July 5 1979		2b. HOUR 7:20 P.M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 11 5 09		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md			13b. COUNTY A.A.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ODEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN R. WARNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215197322		17. INFORMANT ADDRESS C. Carrohn Lee #13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF SMALL</u> <u>179-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTESTINES</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF UTERUS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION <u>3/24/79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SMALL INTEST. OBST.</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> 19 <u>79</u> to <u>7/5</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7/5/79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jesse L. Wilkins, M.D.</u>				22c. DATE SIGNED <u>7/6/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JESSE L. WILKINS, M.D.</u>				22e. ADDRESS <u>98 Cathedral St Annapolis Md. 21401</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>7/8/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	
24. FUNERAL DIRECTOR NAME <u>John M. Lystarson</u>		ADDRESS <u>Annapolis Md</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 10 1979</u>	
25b. REGISTRAR'S NAME <u>John M. Lystarson</u>		ADDRESS <u>Annapolis Md</u>		25c. DATE REC'D. BY REGISTRAR <u>JUL 10 1979</u>	

82101



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16059

1. FOR REGISTRAR										20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> 7 23 1979										2b. HOUR P M	
1a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY Joseph LEYLAND										21. DATE PRONOUNCED DEAD 7 23 1979										2d. HOUR P M	
3. SEX M		4. RACE W		5. DATE OF BIRTH (LAST BIRTHDAY) MONTH DAY YEAR 12 13 26		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS YEARS 52 YRS.		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RHODE Isl.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.									
10. CITY OR TOWN OF DEATH CHEN BUREAU				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Howard Hospt.				12a. USUAL OCCUPATION (TYPE OF WORK) SERVICE STATION OWNER				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MD.				13b. COUNTY AA				14. INSIDE CITY (LIMIT) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				15. STREET ADDRESS 7728 ALPINE BEACH RD.									
14. FATHER'S NAME FRED				15. MOTHER'S MAIDEN NAME SARAH				16. CITY OR TOWN PASADENA				17. STREET ADDRESS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 44-64 638-16-2657				17. INFORMANT ANNE MARIE LEYLAND				ADDRESS #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE E. Linhard				TITLE (SPECIFY) M.D. Reporting				MEDICAL EXAMINER				DATE SIGNED 7/23/79									
EXAMINER'S NAME (TYPE OR PRINT) E. Linhard				ADDRESS Annapolis Md																	
23a. BURIAL, CREMATION, REMOVAL (BY) BURIAL				23b. DATE 7/27/79				23c. NAME OF CEMETERY OR CREMATORY MEADOWBRIDGE				23d. LOCATION (CITY OR TOWN, COUNTY, STATE) ANNAPOLIS MD.									
24. FUNERAL DIRECTOR John M. Lytle				ADDRESS Annapolis, Md				25a. DATE REC'D BY REGISTRAR JUL 27 1979				25b. REGISTRAR'S SIGNATURE [Signature]									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		2b. HOUR	
WALTER A. LOTTMAN Lottman		10 JULY 1979		0201A <sub>M</sub>	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	CAU	APRIL 3, 1925	54 YRS.	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MISSOURI	USA		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Jessups	KIMBROUGH ARMY HOSPITAL		TRUCK DRIVER		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MISSOURI			AFTON	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	ST. LOUIS, MISSOURI 5040 LAKEWOOD
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Lottman		GRACE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
YES		1940-45	WIFE ADDRESS		
		49818 5246	MARGARET LOTTMAN		
18. CAUSE OF DEATH (Enter only one cause per (a) or (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 2500					2 HR. 15 MIN.
DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS					12 YRS
DUE TO, OR AS A CONSEQUENCE OF (c) MORBID OBESITY					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from 10 July 1979, to 10 July 1979, that (X) (we) lost saw the deceased alive on 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (X) (not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
FREDDY J. WILLIAMS, MD				7-10-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
FREDDY J. WILLIAMS, MD				Kimbraugh Army Hospital Fort Meade, Maryland 20755	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	STATE
Burial		July 13, 1979	National Cemetery	St. Louis,	Missouri
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ruck Towson Funeral Home, Inc. Towson, Md. 21204		1050 York Road		JUL 12 1979	Freddy Williams

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 16061			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELsie B MAHLA				2a. DATE OF DEATH MONTH DAY YEAR July 30 1979		2b. HOUR 3:00 PM	
3. SEX Female		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR Sep 13 1890		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 126 Round Bay Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WIFE		12b. KIND OF BUSINESS OR INDUSTRY Home Maker	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD ALONZA BARKLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MADGE KURTZ BARKLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 221-20-9989		17. INFORMANT ADDRESS Edwin B Pierce 800 BRANCH RD NEWARK, DEL.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL Infarction 410 - DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS CARDIOVASCULAR disease 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 30 July 19 79, to 30 July 19 79, that (I) (we) lost saw the deceased alive on 30 July 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE T. C. Cullis MD				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 30 July 79	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) T. C. CULLIS				22f. ADDRESS 7-Biggs Ave Severna Park			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8-2-79		23c. NAME OF CEMETERY OR CREMATORY Purview Cem		23d. LOCATION CITY OR TOWN STATE Wilmington Del.	
24. FUNERAL DIRECTOR NAME Richard Baranco				24b. ADDRESS Severna Park		25. DATE REC'D. BY REGISTRAR AUG 1 1979	

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9 16062

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Edith</i> M. LAST <i>Marshall</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>7 21 79</i>		2b. HOUR <i>7:45 a.m.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 1, 1917</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS. MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Pasadena</i>	
14. FATHER'S NAME FIRST <i>Charles</i> MIDDLE <i>R.S.</i> LAST <i>Miller</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Delia</i> MIDDLE LAST <i>Duffy</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cleaner</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-03-8727</i>		17. INFORMANT ADDRESS <i>Pasadena, Md. 21122</i> <i>Mr. Eugene R. Marshall, Sr. 91 Will-O-Brook Drive</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer Breast</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1978</i> , 19____, to <i>7/21/79</i> , 19____, that (I) (we) lost saw the deceased alive on <i>7/21/79</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>S P Watkins</i>				22c. DATE SIGNED <i>7/21/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S P WATKINS</i>				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>July 24, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>	
24. FUNERAL DIRECTOR NAME <i>Mc Cully Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 23 1979</i>		25b. REGISTRAR'S SIGNATURE <i>History Mcbride</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





Edith

Marshall

Female

Jan 1 1913

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 0 6 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ira Richard Marshall</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7-16-79</b>		2b. HOUR <b>8:45 AM</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12-25-09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.
10. CITY OR TOWN OF DEATH <b>Crownsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairfield Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Employed - Construction Company</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Kothian</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard -- Marshall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Flora A. (nee Layton)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>Richard Marshall-Poolesville, Md.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest -</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension -</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral Vascular Accident - Crows</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 + yrs -</b> <b>10 + yrs -</b>
19a. DATE OF OPERATION <b>7/12/79</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cerebral Vascular Accident</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/12/79</b> to <b>July 19, 79</b> , that (I) (we) last saw the deceased alive on <b>7/12/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Rodney L. Brimhall MD</b>		22c. DATE SIGNED <b>7/16/79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rodney L. Brimhall, M.D.</b>
22e. ADDRESS <b>1407 Forest Drive, Annapolis, Md. 21401</b>		22f. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem.</b>		
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>7/19/79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham (Pr. Geo's) Md.</b>
24. FUNERAL DIRECTOR <b>Richard A. Coleman Funeral Home Upper Marlboro, Maryland 20870:</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 26 1979</b>	

24. FUNERAL DIRECTOR  
**Richard A. Coleman Funeral Home  
Upper Marlboro, Maryland 20870:**

25a. DATE REC'D. BY REGISTRAR  
**JUL 26 1979**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1992

Author's address: Department of Mathematics,  
University of Illinois at Chicago, Chicago, IL 60607-7141

JUL 2 1979

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 1 6 0 6 4  
ESTFOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH STEPHEN MATTHEWS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 16, 1979</b>		2b. HOUR <b>4:57P M</b>	
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 26, 1962</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>17</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jeremiah Matthews</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Hadaway</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-88-1778</b>		17. INFORMANT <b>Jeremiah Matthews</b>		
				ADDRESS <b>same as 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <b>4279 Ventricular Arrhythmia</b> IMMEDIATE CAUSE (a) <b>Due to, or as a consequence of</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>sinus node dysfunction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Due to, or as a consequence of</b> (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cordiac Pacemaker</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8-14, 1975</b> , to <b>6-12, 1979</b> , that (I) (we) lost saw the deceased alive on <b>6-12, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/18/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR M. ROLAND</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/20/1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		
24. FUNERAL DIRECTOR NAME <b>Mc Cully, F.H. Mountain &amp; Tick Neck Rds. Pa., Md.</b>		ADDRESS <b>21122</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. MD.</b>		
25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



JOSEPH STEPHEN MATTHEW JULY 16, 1901

X ANNE RUDOLPH COUNTY

CLEAR BURNIE NORTH RUDOLPH HOSPITAL

JOHN S. HOPKINS HOSPITAL

DR. M. ROLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 16065		D.S.T.	
1. FOR STATE REGISTRAR Items 19a. 21a. - 21f. & 22a. Film G534 8-7-79 as										2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BESSIE W. MC CLOSKEY</b>										MONTH DAY YEAR <b>JULY 13, 1979</b>		5:23 A.M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 8, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.							
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto G&amp;E</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>										13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Pasadena</b>	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>212 05 5552</b>		17. INFORMANT ADDRESS <b>Mr. Newton Hayden same as 13 e</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>FX - (L) Femur</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7/13/79</b> <b>3/31/79</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>ASLVD</b>													
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 3 31 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>Patient fell at N.H.</b>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Nursing Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Glen Burnie Md.</b>									
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 31, 1979</b> to <b>JULY 13, 1979</b> , that (I) (we) lost saw the deceased alive on <b>JULY 12, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. <b>Natural</b>													
22b. SIGNATURE <b>Neil M. Keats</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NEIL M. KEATS, M.D.</b>		22e. ADDRESS <b>513 EMPIRE TOWERS, 7300 RITCHIE HIGHWAY, GLEN BURNIE, MARYLAND 21061</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/16/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Ph</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>							
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hgwy</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

BP

W. J. MC CLOSKEY

JULY 13, 1970

ALICE BRUNDEL COUNTY

GLENN BRUNDEL HOSPITAL

X

WILLIAM KEATS, M.D.

419 EMPIRE TOWER, 1000 WITCHELL  
HIGHWAY, GLEN BRUNDEL, MARYLAND 21081

JUL 1 1970



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A) 15 ME (5)  
15M 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

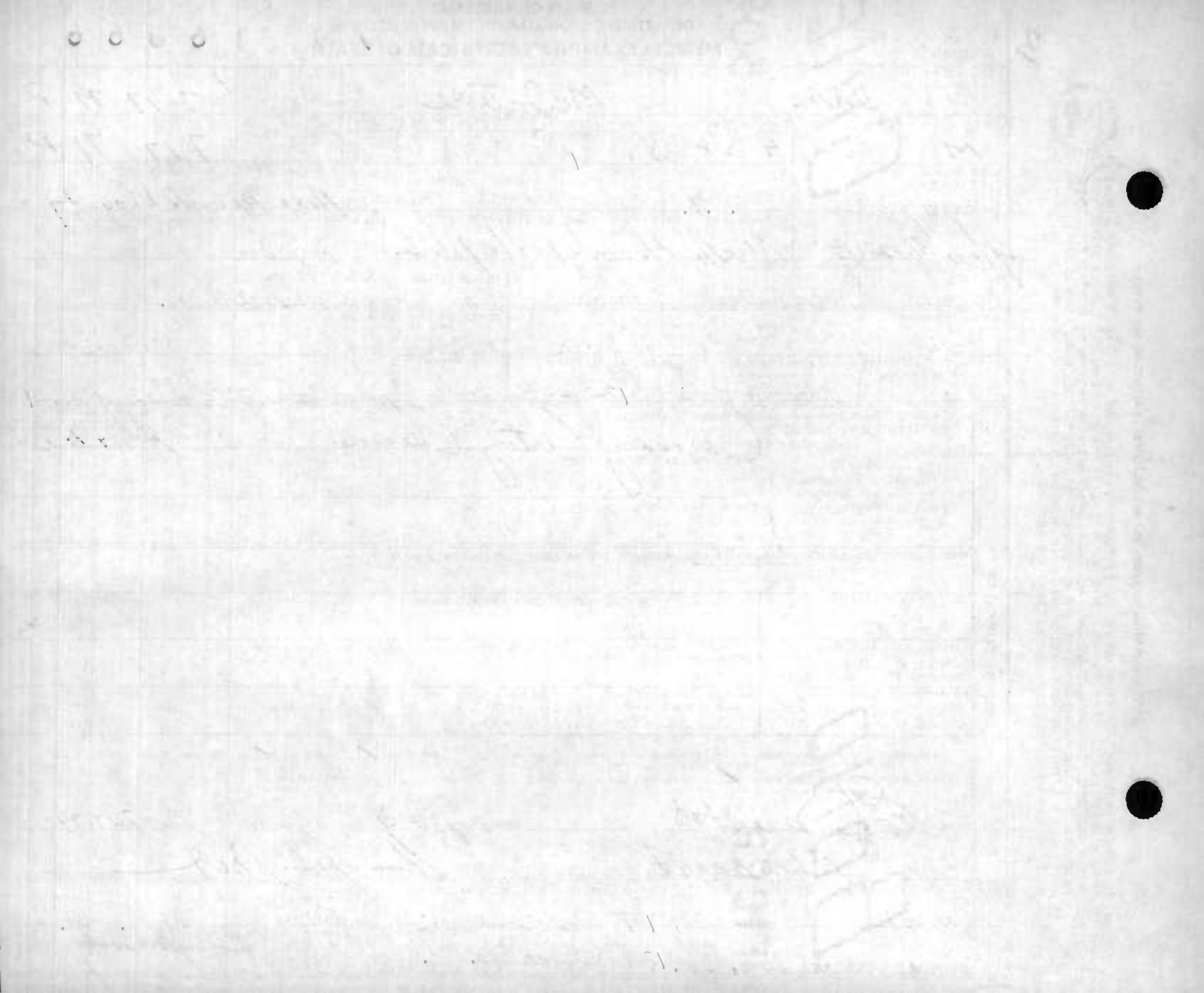
REG. NO.

16066

3  
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DAVID</b>			FIRST			MIDDLE			LAST <b>McIntyre</b>			20. DATE KNOWN OF DEATH ESTIMATED <b>7 17 1979</b>			2b. HOUR <b>P</b>				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>22</b> YEAR <b>38</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.			IF UNDER 1 YR. MONTHS <b>4</b> DAYS <b>1</b> HOURS <b>1</b> MIN.			7c. DATE PRONOUNCED DEAD <b>7 17 1979</b>			2d. HOUR <b>P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Green Borne</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bartender</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Anne Arundel</b>				13c. CITY OR TOWN <b>Ferndale</b>				13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>205 Oakleigh Ave.</b>					
14. FATHER'S NAME FIRST <b>David</b> MIDDLE <b>Mc</b> LAST <b>Intyre</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Ann</b> MIDDLE <b>Broderick</b> LAST <b>Broderick</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>Korean Conflict 013-29-9884</b>				17. INFORMANT <b>Donna Glydden Baker</b> ADDRESS <b>205 Oakleigh Ave. 9</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Stroke</b>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) <b>M.D. Dept 9</b>				MEDICAL EXAMINER				DATE SIGNED <b>7.17.79</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt</b>				ADDRESS <b>Chesapeake, Md</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>July 20, 1979</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home, Inc.</b> ADDRESS <b>1328 Sulphur Spr. Rd.</b>				25. DATE REC'D. BY REGISTRAR <b>JUL 18 1979</b>				25b. REGISTRAR'S SIGNATURE <b>Dickie McBrady</b>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 6 0 6 7

D.S.T.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST KEVIN	MIDDLE ROBERT	LAST MCNAMEE	2a. DATE OF DEATH MONTH JULY	DAY 9,	YEAR 1979	2b. HOUR 10:10P
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH Jan.	DAY 13,	YEAR 1959	6. AGE (IN YEARS LAST BIRTHDAY) 20	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Athens Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student		12b. KIND OF BUSINESS OR INDUSTRY -----					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.	13b. COUNTY A.A. Co.	13c. CITY OR TOWN Odenton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 533 King Malcolm Ave.						
14. FATHER'S NAME FIRST Robert L. McNamee			15. MOTHER'S MAIDEN NAME FIRST Joan		15. MOTHER'S MAIDEN NAME MIDDLE Dorothy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Robert L. McNamee same as 13 e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ewing's SARCOMA</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/17/77</u> , 19 <u>77</u> , to <u>7/19</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased <u>7/19</u> , 19 <u>77</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Glenn Robbins</u>						DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN ROBBINS M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. ADDRESS GLEN BURNIE, MARYLAND 21061										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/79		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN Arlington Va.		COUNTY STATE		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home						ADDRESS 12 Ridgely Av. Ann. Md.		25a. DATE REC'D. BY REGISTRAR JUL 11 1979		
						25b. REGISTRAR'S SIGNATURE <u>Rita McNeely</u>				

MEDICAL CERTIFICATION



1000  
10:10  
JULY 9, 1979

KEVIN ROBERT MCINANE

WHITE ALMOND COUNTY

CLYDE CURRIE NORTH ALMOND HOSPITAL

1000 CENTRAL HIGHWAY SOUTH  
GREENBURG, WYOMING 82801

CLYDE CURRIE M.D.

JUL 11 1979



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 6 0 6 8 REG. NO. 20pm				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUGENE EDWARD MILLER					2a. DATE OF DEATH MONTH DAY YEAR 07 21 79 2b. HOUR 1820				
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 20 1891		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY ANN 13c. CITY OR TOWN Annapolis					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1020 PINECREST DR.		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE MILLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE DEHOFF							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY N. (IF YES, GIVE WAR OR DATES) 215100486		17. INFORMANT ADDRESS BEWE BUCHANAN #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (H) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JON B HOWE					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 21 6 79		
22e. ADDRESS 121 CATHEDRAL ST. Annapolis, MD.									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 7/24/79		23c. NAME OF CEMETERY OR CREMATORY GREENLAND MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.			
24. FUNERAL DIRECTOR [Signature] 24b. ADDRESS Annapolis, Md.					25a. DATE REC'D. BY REGISTRAR JUL 26 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

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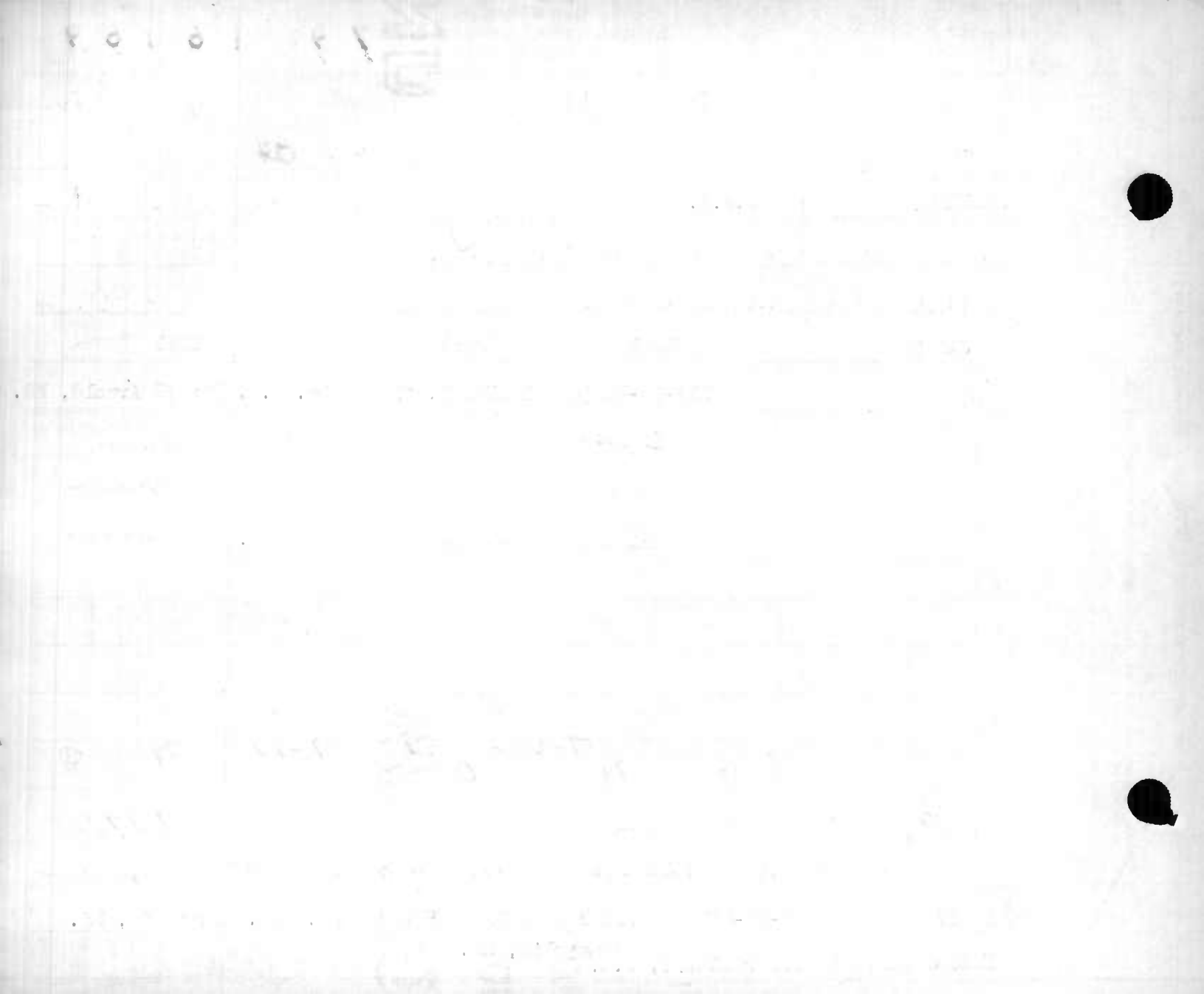
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 6 0 6 9									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Florida		J				Miller		7 16 79		935 PM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
female		black		7 3 95		84 84 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				Anne Arundel County					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Annapolis		Anne Arundel General Hospital									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
md		Anne Arundel		Arnold		YES <input type="checkbox"/> NO <input type="checkbox"/>		P.O. 52			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
JAMES		HOONEY		MARY		HOONEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS							
NO		215-32-2423A		WILLIAM H. MILLER Sr. P.O. Box 52 Arnold, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CVA										2 mos.	
4029 DUE TO, OR AS A CONSEQUENCE OF (b) 1st A. CVA										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Renal insuff.										months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7-24-19 56, to 7-16-19 79, that (I) (we) lost saw the deceased alive on 7-16-19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE								22c. DATE SIGNED	
Faye W. Allen		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								7/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
FAYE W. ALLEN		111 Cathedral St Annapolis, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		7-20-1979		ASBURY BROADNECK CHURCH		CEME. St. Margarets, Md.					
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
WILLIAM REESE & SONS MORTUARY, P.A.		Annapolis, Md.		JUL 20 1979		[Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 16070				
1. FOR STATE REGISTRAR					REG. NO.					DST				
1. DECEASED NAME (TYPE OR PRINT) LOLA VIRGINIA MILLER					2a. DATE OF DEATH MONTH DAY YEAR July 21, 1979					2b. HOUR A. 11:12 M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.								
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed			12b. KIND OF BUSINESS OR INDUSTRY Fencing Ser.					
13a. STATE Maryland					13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1873 Potomac Road Pasadena, Md. 21122		
14. FATHER'S NAME FIRST MIDDLE LAST Harry Elliott					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Hill					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 214-18-2943	
17. INFORMANT Mr. Leslie O. Miller 1873 Potomac Road					18. ADDRESS Pasadena, Md. 21122									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Extensive Pancreatic Carcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2 hours 2 1/2 months				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Profuse Vaginal Bleeding</u>														
19a. DATE OF OPERATION July 14, 1979				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Duodenal Obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Antonio Cardula				DEGREE —				22c. DATE SIGNED July 22, 1979						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO O. GATDULA, MD				22e. ADDRESS 300 Hospital Drive, #30 Glen Burnie, Maryland, 21061										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 24, 1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Anne Arundel Md.						
24. FUNERAL DIRECTOR NAME Mc Cully F. Funeral Home of Pasadena				24b. ADDRESS Mountain and Lick Neck Roads Pasadena, Md. 21122				25a. DATE REC'D. BY REGISTRAR JUL 23 1979						

MEDICAL CERTIFICATION

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CHILLYAM

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		<input type="checkbox"/> MONTH	<input type="checkbox"/> DAY	<input type="checkbox"/> YEAR	2b. HOUR
Robert William Miller, Jr.					7 3 1979					P M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD	7d. HOUR
Male	White	6 21 76		53 YRS.					7 3 1979	P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.					Anne Arundel MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie		North Arundel Hospital				Turbine Operator		Gas & Elec		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Anne Arundel		Glen Burnie				1046 Dumbarton Road		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Robert W. Miller, Sr.				Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Son)		ADDRESS				
Yes		WWII		377/20/6345		Robert W. Miller, III Rd. Linth., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>E. Linhardt</u>				TITLE (SPECIFY) M.D. <u>Deputy</u> MEDICAL EXAMINER				DATE SIGNED <u>7.4.79</u>		
EXAMINER'S NAME (TYPE OR PRINT) <u>E. Linhardt</u>				ADDRESS <u>Annapolis, Md</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		July 7, 1979		Glen Haven Cem.		Glen Burnie A.A.Co. Md.				
24. FUNERAL DIRECTOR NAME <u>Singleton</u> ADDRESS _____				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Singleton Funeral Home, Glen Burnie, Md.				JUL 10 1979		<u>Jeffrey H. Hardy</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 6 0 7 2		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA Alma MILLS</b>				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 5, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>122 Spruce Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>C &amp; P Telephone</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Co. Retired</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>122 Spruce Lane</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Annapolis</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mathews Heinz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Urta May Wood</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-18-7237</b>		17. INFORMANT ADDRESS <b>Leroy W. Mills (same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>of breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 mos</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 7-28</b> , 19 <b>79</b> , to <b>7-28</b> , 19 <b>79</b> that (I) (we) lost saw the deceased alive on <b>7-28</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Carl R. Holschult</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7-29-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KARL R. HOLSCHULT</b>				22e. ADDRESS <b>104 Forbes St</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 1, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis, Anne Arundel, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home, 1212 West St., Anna., Md.</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>AUG 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 16073

1- FOR  
STATE  
REGISTRAR

REG. NO. DST

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
Wiley Edgar Mills, Sr.			July 29, 1979			6:52 P M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male		White		April 4, 1921		58 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
Salem, Virginia			U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH					
						Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Glen Burnie			North Arundel Hospital						Minister		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Anne Arundel			Severn			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
William			Mills			Unknown			17. INFORMANT (Wife)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Subacute Cardiovascularopathy</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Rheumatic Heart Disease</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Rheumatic Heart Disease</i>			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. I certify that (I) (this hospital) attended the deceased from 7-20, 1979, to 7-23, 1979, that (I) (we) lost saw the deceased alive on 7-29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <i>Hilary T. O'Herlihy, M.D.</i>			22c. ADDRESS 325 Hospital Drive, #208 Glen Burnie, Md. 21061			22d. DATE SIGNED 7/29/79		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Aug. 1, 1979			Glen Haven Cem.			Glen Burnie, A.A., Maryland		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
J. Easter						JUL 31 1979			<i>Robert M. Brady</i>		
Singleton Funeral Home, Glen Burnie, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 6 0 7 4		D.S.T.	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) CATHERINE NMI MISOVITZ				MONTH DAY YEAR JULY 29, 1979		7:00 A.M.	
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 11 25 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1311 Stony Lane 27022	
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Crownsville			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Cassup		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 2130 10- 6835		17. INFORMANT Gregory M.		ADDRESS Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intoxicerebral Hemorrhage</u> <u>431-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/26/79</u> to <u>7/29/79</u> , that (I) (we) last saw the deceased alive on <u>7/28/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Basant K. Khandelwal</u> DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/29/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHANDELWAL, M.D.				22e. ADDRESS 205 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-31-79		23c. NAME OF CEMETERY OR CREMATORY Our Lady of The Fields		23d. LOCATION CITY OR TOWN COUNTY STATE Gambrells A.A. Md.	
24. FUNERAL DIRECTOR NAME T. A. Hardesty 12 Ridgley Ave. Annapolis Md.				25a. DATE REC'D. BY REGISTRAR AUG 1 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McBrady</u>	



CATHERINE I. KISVITS

JULY 20, 1975 12:00

ELLEN BERNIE HODIN BERNICE HODIN

1975-1-3

ON 7/20/75

THOMAS T. WHANDER, JR. D.D. J. E. BARTHOLOMEW, JR. D.D. BOURGEOIS

NOV 1 1975

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G534 8/29/79 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1- STATE REGISTRAR										
REG. NO. 16075										
1. DECEASED NAME (TYPE OR PRINT) <b>BEVERLY ANNE MOORE</b>					2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR <b>7 19 79 7:00</b>					
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 29 1948</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>31 YRS.</b>		7. DATE PRONOUNCED DEAD MONTH DAY YEAR HOUR <b>7 19 79 7:00</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Social Worker Volunteer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>680 AMERICANA DR.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN B MOORE JR.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HILDA MOORE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220-52-8512</b>			17. INFORMANT ADDRESS <b>JOHN B MOORE JR.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9503</b> IMMEDIATE CAUSE (a) <u>Acute amitriptyline intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self-ingested</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION <b>680 Americana Dr. Apt. 32 Annapolis, Md.</b>					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Margareta Korell</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>7/20/79</b>		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>7-20/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PG MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>JOHN M. TAYLOR &amp; SONS ANNAPOLIS, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles E. Moser		2a. DATE OF DEATH MONTH DAY YEAR 7 18 79		2b. HOUR 3:15 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 10 31		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technical Instr.		12b. KIND OF BUSINESS OR INDUSTRY Bendixville Eng.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Pr. Geo.	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 12706 Midwood Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Moser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Doorenkemper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1950-1971	17. INFORMANT ADDRESS Nancy C. Moser Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Stephen B. Hiltabidle</u>		DEGREE M.D.		22c. DATE SIGNED JUL 24 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen B. Hiltabidle		22e. ADDRESS 801 Melvin Ave. Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-23-79	23c. NAME OF CEMETERY OR CREMATORY Memphis National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Memphis Shelby Tenn.
24. FUNERAL DIRECTOR NAME Robert G. Beall Funeral Home 9013 Annapolis Rd. Lanham, Md.			25a. DATE REC'D. BY REGISTRAR JUL 24 1979		25b. REGISTRAR'S SIGNATURE <u>Henry H. Brady</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		7 9 16077		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Genevieve M Mould				July 6, 1979	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		Cauc.		August 1st, 1893	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
Washington D C		USA		85 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Edgewater		1705 Longwood Road		Anne Arundel MD.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Anne Arundel		Edgewater	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Earl R. Smith		Margaret Graves		13e. STREET ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
No		577-48-6468		Helen Lowe (Sister) As in Item 13a	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac failure</u>					
4140 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral artery arteriosclerosis</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 19 <u>70</u> to <u>6 Jul</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7-7</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
<u>William H. Choate, MD</u>		6 Jul 79		WILLIAM H. CHOATE, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7-9-1979		Mount Olivet Cem.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
George P. Kalas Funeral Home		6160 Oxon Hill Rd. Oxon Hill, Md.		JUL 12 1979	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
				R. H. H. H. H.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR Items 19b 9/24/79cn		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7 9 1 6 0 7 8		DST	
1. STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY VIRGINIA NESERKE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 19, 1979</b>		2b. HOUR <b>11:11<sup>A</sup><sub>M</sub></b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 22, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>86 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>A.A.Co.</b>		13c. CITY OR TOWN <b>Glen Burnie</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Guy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Turner</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216/05/9869</b>		17. INFORMANT (Son-in-law) ADDRESS <b>Mr. Raymond L. Atwell Same as 13</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5570</b> IMMEDIATE CAUSE (a) <b>Mercantile Pain Thrombosis</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs.</b>	
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Hypertension - Reluctant Heart Murmur</b>							
19a. DATE OF OPERATION <b>7-15-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute Surgical Abdomen</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-15-79</b> , 19____, to <b>7-19-79</b> , 19____, that (I) (we) last saw the deceased alive on <b>7-19-79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles R. MacDonald M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7-19-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAC DONALD, CHARLES R., M.D.</b>				22e. ADDRESS <b>325 HOSPITAL DRIVE, GLEN BURNIE, MD. 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 23, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A.Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>G. Easter</b>				ADDRESS <b>Singleton Funeral Home Glen Burnie, Md.</b>		25. DATE REC'D BY REGISTRAR 25b. REGISTRAR <b>JUL 20 1979</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 16079 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
GEORGE PRESTON		NEWMAN						7/17/79 8:00 AM	
3. SEX		RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
MALE		WHITE		3 18 1915		64		MONTHS DAYS HOURS AM.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
VIRGINIA		USA				Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel General Hospital		PAINTER		HOUSE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD.		A.A.		GAMBRILLS		RT. 175 Box 54			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
CHARLIE		NEWMAN		NO		237-03-7602		WANDA NEWMAN #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629		Metastatic Lung Cancer		8 months					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				12/28 78 7/17 79					
22a. I certify that (1) (this hospital) attended the deceased from 7/16 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		E. W. COLE		MD		7/18/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
E. W. COLE		121 CATHEDRAL ANNAPOLIS		BURIAL		7-20-79		HILLCREST	
24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOHN M. TAYLOR & SONS		ANNAPOLIS, MD.		11/1 20 1979					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 16080			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Elias W Nuttle</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>7 1 79</u>		2b. HOUR <u>6:00 PM</u>	
3 SEX <u>M</u>		4 RACE <u>White</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>Nov. 2 1902</u>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <u>76</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel County, MD.</u>	
10 CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Businessman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>	
13a. STATE <u>Md</u>		13b. COUNTY <u>Caroline</u>		13c. CITY OR TOWN <u>Denton</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>Frank D. R. Nuttle</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Martha Emily Everngam</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Unknown</u>		16b. SOCIAL SECURITY NO <u>220-26-3425</u>		17 INFORMANT wife <u>Dorothy Nuttle</u>		ADDRESS <u>Denton, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Nervous System infarct</u> 4331 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Artery Stenosis</u> 3mo DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 hr</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION <u>6/29/79</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cerebral Artery Stenosis</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>(did not)</u> attend the deceased from <u>June 29</u> , 19 <u>79</u> , to <u>1 July</u> , 19 <u>79</u> , that (I) <u>(did)</u> last saw the deceased alive on <u>1 July</u> , 19 <u>79</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> <u>(did not)</u> view the body after death.							
22b. SIGNATURE <u>Gary M. O'Neil, MD</u>				DEGREE <u>ATTENDING PHYSICIAN</u> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7-1-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GARY MEADE RICHARDSON</u>				22e. ADDRESS <u>104 Forbes Street, Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>July 5, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Denton Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Denton Caroline Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Charles Moore</u>				ADDRESS <u>Denton, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 6 1979</u>	
				25b. REGISTRAR'S SIGNATURE <u>Richard McCreedy</u>			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16081  
REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
John K. Odell		Male		White	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE PRONOUNCED DEAD	
March 25, 1961		18 YRS.		7 18 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Davidsonville		Farm, Governor Bridge Road		Aluminum Siding Work	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
Maryland		Anne Arundel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS	
Vermin		O'Dell		864 Dogwood Trail	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
no		215-74-8211		Reba Q. Smith (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Drowning					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR XX MONTH DAY YEAR 10+ P.M. 7 17 19 79		Subject drowned while swimming	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		pond		Farm on Governor Bridge Rd., Davidsonville, A.A., Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Virginia L. Dolan		Assistant		7/18/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Virginia L. Dolan, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		07-21-79		Hillcrest Cemetery	
23d. LOCATION (CITY OR TOWN)		COUNTY		STATE	
Annapolis		Anne Arundel		Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Beall Funeral Home, 1212 West St., Anna., Md.		JUL 23 1979		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79 16082				D.S.T.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANET C. O'DONNELL				2a. DATE OF DEATH MONTH DAY YEAR JULY 26, 1979				2b. HOUR A.M. 3:42 M			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 3, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Postal Service			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Pasadena				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 260 Maryland Ave. Pas. Md. 21122					
14. FATHER'S NAME FIRST MIDDLE LAST Henry Motter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT Hugh O'Donnells, Jr.				ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Pump Failure 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Excessive Arterial Blood Pressure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days? 7-24-79 Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-28, 1979, to 7-26, 1979, that (I) (we) last saw the deceased alive on 7-26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Hilary T. O'Herlihy				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-26-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HILARY T. O'HERLIHY, M.D.				22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 208 GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/28/1979		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Men. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Anne Arundel, Md.					
24. FUNERAL DIRECTOR NAME Mc Cully F.H. Mtn. & Tick Neck Rds., Pasadena, Md.				ADDRESS 21122		25a. DATE REC'D. BY REGISTRAR JUL 27 1979		25b. REGISTRAR'S SIGNATURE Hilary T. O'Herlihy			

BP



10083

JULY 26, 1955

OLDOMELLE

PAID

ANNE ARNOLD COUNTY

ELLEN EUBANK NORTH ARNOLD HOSPITAL

x

DATE

AMOUNT

*[Faint, illegible handwritten notes]*

WILLIAM T. O'BRIEN, M.D.  
202 HOSPITAL DRIVE, SUITE 202  
ELEN EUBANK, ARNOLD, MD.

*[Faint, illegible handwritten notes]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 1/71 30M  
(VR A15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

16083

1. DECEASED NAME (Type or print) <b>IRENE ELLA OLESEN</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1979</b>			2b. HOUR <b>P M</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Oct. 8, 1940</b>		6. AGE (In years last birthday) <b>38</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel</b> Md.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>615 Burley Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>615 Burley Road</b>	
14. FATHER'S NAME First <b>George</b> Middle <b>B.</b> Last <b>Minor</b>			15. MOTHER'S MAIDEN NAME First <b>Lutie</b> Middle <b>Giles</b> Last <b>Giles</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>214-38-8640</b>		17. INFORMANT Address <b>Ole E. Olesen (same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition Secondary to Carcinoma of unknown</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Primary unknown.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> , 19 <b>79</b> , to <b>7/2/79</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/26</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Daniel C. Wilkerson</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/3/79</b>			
22d. PHYSICIAN'S NAME (Type) <b>Daniel C. Wilkerson, M.D.</b>		22e. ADDRESS <b>1563 St. Margarets Rd., Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>07-04-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Alexandria, Arlington, Va.</b>			
24. FUNERAL DIRECTOR <b>Beall Funeral Home, 1212 West St., Anna., Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>			

MEDICAL CERTIFICATION

IN SENATE,  
January 1, 1910.  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 1, 1909.

ALBANY:  
J.B. LIPPINCOTT & CO.,  
PRINTERS,  
1910.

THE COMMISSIONER OF THE LAND OFFICE  
HAS THE HONOR TO ACKNOWLEDGE  
THE RECEIPT OF THE REPORT  
OF THE COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 1, 1909.

IN SENATE,  
January 1, 1910.  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 1, 1909.

ALBANY:  
J.B. LIPPINCOTT & CO.,  
PRINTERS,  
1910.





Item 6 533 7/13/79 gj

FOR #5  
1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 7 9 1 6 0 8 4

1. DECEASED NAME (TYPE OR PRINT) <b>CHESTER</b>		FIRST <b>OLIVER, JR.</b>		MIDDLE <b>OLIVER, JR.</b>		LAST <b>OLIVER, JR.</b>		2a. DATE OF DEATH MONTH <b>JULY</b>		DAY <b>4</b>		YEAR <b>1979</b>		2b. HOUR <b>6P</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>3</b>		DAY <b>16</b>		YEAR <b>1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS		IF UNDER 1 YEAR MONTHS <b>50</b>		IF UNDER 24 HRS HOURS <b>50</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE ANNE ANN, G MD.</b>									
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOME</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>SEVERN MD 21144</b>					
14. FATHER'S NAME FIRST <b>CHESTER</b>				MIDDLE <b>OLIVER</b>		LAST <b>OLIVER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>BLANCHE</b>				MIDDLE <b>G AMBRIELS</b>		LAST <b>G AMBRIELS</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT <b>Dorothy Oliver</b>				ADDRESS <b>1359 Hanover St</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>CANCER OF PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6mo</b>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION <b>6/12/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>OBSTRUCTIVE JAUNICE</b>						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from <b>5/31/79</b> , 19 <b>79</b> , to <b>7/4</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>JULY 3</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)															
22b. SIGNATURE <b>Anthony J. Raneri MD</b>										DEGREE <b>MD</b>		22c. DATE SIGNED <b>7/5/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. J. RANERI</b>										22e. ADDRESS <b>3001 S. HANOVER ST BALTO 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/9/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Rest Cem.</b>				23d. LOCATION CITY OR TOWN <b>Harmon, Md.</b>		COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Wm C March F / H</b>										ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 16085					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		21. HOUR			
Stanley		J		ASHINSKI				7		11		19		79		P		M			
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		21. HOUR	
M		W		7-29-41		37 YRS.						7		11		19		79		P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Pennsylvania		USA				A.A.C.U.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Annapolis		Boat - Yacht Inc - 2nd St		Technical Consultant																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS													
Maryland		Anne Arundel		Annapolis				722 Second Street													
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST											
Stanley				Oshinski		Catherine				Brazinski											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
Yes		193-30-3243		Grontkowski Funeral Home, Pennsylvania																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>Instant</u>																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy 2		MEDICAL EXAMINER														DATE SIGNED		7-11-79	
EXAMINER'S NAME (TYPE OR PRINT)		E. L. H. B. R. K. S. T.		ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE											
Removal - Burial		07-14-79		Holy Trinity Cemetery		Nanticoke, Lucerne, Pa.															
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR																		25b. REGISTRAR'S SIGNATURE	
Beall Funeral Home, 1212 West St., Anna., Md.		JUL 16 1979																		H. B. R. K. S. T.	



*[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 1 6 0 8 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Galloway NMN Parker Jr.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>7 20 79</b>		2b. HOUR <b>12:45 PM</b>	
3 SEX <b>Male</b>	4 RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 14 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A.A. GEN. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sup. A.A. Co. Md</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Annapolis</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>19 Carver Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Galloway Parker Sr</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy NMN Washington</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Galloway L. Parker Same As 13E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>A.C.V.D.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-15-79</b> , to <b>7-20-79</b> , that (I) (we) lost saw the deceased alive on <b>7-19-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A.T. Allen</b>		DEGREE <b>CND</b>		22c. DATE SIGNED <b>7-20-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.T. ALLEN</b>		22e. ADDRESS <b>111 Cochran St</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-25-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>JUL 23 1979</b>		23f. REGISTRAR'S SIGNATURE <b>H. H. H. H.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>C.E. Hicks II Annapolis Md.</b>					



FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7 9 1 6 0 8 7

1. DECEASED-NAME (Type or Print)			First <i>Henry</i>	Middle <i>E</i>	Last <i>Parker</i>	2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR MATED <input type="checkbox"/> 7 15 1979			2b. HOUR A M	
3. SEX <i>M</i>	4. RACE <i>N</i>	5. DATE OF BIRTH <i>9-9-13</i>	6. AGE (in years last birthday) <i>65</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month 7 Day 15 Year 1979		2d. HOUR A M
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co</i>				
10. CITY OR TOWN OF DEATH <i>Annapolis</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Anne Arundel General</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before) <i>MARYLAND</i>			13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>CHURCHTON</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>44 E. Bayfront Rd.</i>	
14. FATHER'S NAME First Middle Last <i>GEORGE WASHINGTON</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>MARY BLAKE</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT ADDRESS <i>GEORGE PARKER Box 12 Galesville, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>9534</i> <i>fractured humerus chest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>7-15-79</i>
ADDRESS (Street, city, town, or county) <i>Annapolis, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>7-20-1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CHEWS CHURCH CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>Owensville Maryland</i>				
24. FUNERAL DIRECTOR <i>WILLIAM REESE &amp; SONS MORTUARY, P.A.</i>				25a. REC'D BY REGISTRAR DATE <i>JUL 20 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i>				

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 0 8 8  
REG. NO.

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Mary E Pindell		7 1 6 1 9		12 27 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	BLACK	MONTH DAY YEAR	82 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.	XX	ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
ANNAPOLIS	ANNE ARUNDEL GENERAL HSPITAL				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
13a. STATE	13b. COUNTY	YES <input type="checkbox"/> NO <input type="checkbox"/>	157 Graves Road		
MARYLAND	A.A.				
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
CHARLES PINDELL	CATHERINE BROWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO	214-05-1061	RICHARD JAMES Sr. Alexandria, Va. 7996 Audubon Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) cardiac arrest,					
DUE TO, OR AS A CONSEQUENCE OF					30 MIN
(b) POSSIBLE PULM EMBOLUS					
DUE TO, OR AS A CONSEQUENCE OF					6 HRS.
(c) POSSIBLE CANCER of colon.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this <del>person</del> ) attended the deceased from OCT 19 76, to JULY 19 79, that (I) <del>was</del> last saw the deceased alive on APPROX JUNE 20, 19 79, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Harvey J. Steinfeld		M.D.		7-7-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Harvey J. STEINFELD		Shady Side Md 20867.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL		7-9-1979	PINELAWN MEM. PARK		Annapolis A.A. Maryland
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
WILLIAM REESE & SONS MORTUARY, P.A.		Annapolis, Md.		JUL 9 1979	William Reese

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JAMES EARL RAY, JR. &amp; SONS, INC.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										16089 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ROGCK J Polak</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>7 1 79</b>		2b. HOUR <b>14</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>8</b> YEAR <b>24</b>		6. AGE IN YEARS (LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		2c. DATE PRONOUNCED DEAD MONTH <b>7</b> DAY <b>1</b> YEAR <b>79</b>		2d. HOUR <b>PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co MD.</b>			
10. CITY OR TOWN OF DEATH <b>Severna Park</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>505 G.I.B. Ckt.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>			
13a. STATE <b>MD</b>													
13b. COUNTY <b>A.A.</b>				13c. CITY OR TOWN <b>Severna Park</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>505 Lib Ct.</b>			
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Polak</b> LAST <b>Polak</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Theresa</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>						16b. SOCIAL SECURITY NO. <b>U.S. II 077-18-4989</b>		17. INFORMANT ADDRESS <b>Pam Polak - Falls Church</b>					
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>Coronary Artery Disease</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>E. Linhardt MD</b>						TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER						DATE SIGNED <b>7-1-79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt</b>						ADDRESS <b>Annapolis, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cem.</b>				23d. LOCATION CITY OR TOWN <b>Annapolis</b> COUNTY <b>Prince Georges</b> STATE <b>Md</b>			
24. FUNERAL DIRECTOR NAME <b>Robert S. Barranco</b> ADDRESS <b>501 Ritchie Hwy Severna Park MD.</b>						25a. DAY <b>JUL 5 1979</b>		25b. REGISTRAR'S SIGNATURE					

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 16090

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WALTER PORTER</b>		2a. DATE OF DEATH MONTH <b>7</b> DAY <b>16</b> YEAR <b>79</b>		2b. HOUR <b>3:20 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>4</b> YEAR <b>1920</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b>		7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>7843 Clarkstation Rd.</b>	
14. FATHER'S NAME FIRST <b>WALTER</b> MIDDLE <b>JOHN</b> LAST <b>PORTER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>BLANCHE</b> MIDDLE <b>GRiffin</b> LAST <b>GRiffin</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.LI</b>		17. INFORMANT ADDRESS <b>ADA PORTER 7843 Clarkstation Rd. Severn, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYO CARDIAC INFARCTION</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>54 YRS.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5-25</b> , 19 <b>64</b> , to <b>7-16</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>4-30</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Leon C. Perry M.D.</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-18-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEON C. PERRY M.D.</b>		22e. ADDRESS <b>325 HOSPITAL DR. GLEN BURNIE, MD 21061</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>7-20-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Church Ceme, Arnold A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>		ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1979</b>	
		25b. REGISTRAR'S SIGNATURE <b>Robert H. Brandy</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 6 0 9 1 REG. NO.		DST							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILBERT G. PRESBURY Jr						2a. DATE OF DEATH MONTH DAY YEAR 7 1 1979			2b. HOUR P M 1:15 P M		
3. SEX M		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 7 27 16		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S. A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.					
10. CITY OR TOWN OF DEATH Baltimore County		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Meat Packing			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Lemon Hill Manor			
14. FATHER'S NAME FIRST MIDDLE LAST WILBERT G. PRESBURY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA JONE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 104-45-22946		17. INFORMANT JOAN GREEN		ADDRESS 1506 N. Carroll St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Empyema left 1501 DUE TO, OR AS A CONSEQUENCE OF (b) post operative pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Ca of Thoracic esophagus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 6/18/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Thoracic esophagus				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/1/79, 19 79, to 7/1, 19 79, that (I) (we) last saw the deceased alive on 7/1, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE George S. Tan, M.D.				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George S. Tan, M.D.				22e. ADDRESS 4306 Belle Grove Rd. Baltimore, Md. 21225							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/5/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION CITY OR TOWN COUNTY STATE D.C. County Md					
24. FUNERAL DIRECTOR NAME LOCK'S FUNERAL HOME				ADDRESS 1304 N. Central		25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE Ruth A. [Signature]			

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U. S. DEPARTMENT OF JUSTICE

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DHMH-16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

D.S.T.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BENJAMIN PARKER PRIDDY</b>			2a. DATE OF DEATH MONTH <b>JULY</b> DAY <b>31</b> YEAR <b>1979</b>			2b. HOUR <b>11:40</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Nov.</b> DAY <b>2</b> YEAR <b>1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		# UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		# UNDER 24 HRS HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>							
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Superintendent</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construct.</b>				
13a. STATE <b>Maryland</b>						13b. COUNTY <b>AnneArundel</b>		13c. CITY OR TOWN <b>GlenBurnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4 Forest Street</b>	
14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b></b> LAST <b>PRIDDY</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b></b> LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>544-10-3256</b>		17. INFORMANT ADDRESS <b>Same as # 13</b> <b>Mrs. Myrtle G. Priddy (WIFE)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Failure</b> <b>4/40</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BPND</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>EVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>EVA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/6/79</b> 19, to <b>7/31/79</b> , that (I) (we) last saw the deceased alive on <b>7/31/79</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Jorge B. Ramirez</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/1/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JORGE B. RAMIREZ, M.D.</b>						22e. ADDRESS <b>325 HOSPITAL DRIVE SUITE 207 GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>1, AUG '79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process, Inc. Catonsville</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md</b>					
24. FUNERAL DIRECTOR NAME <b>Alciman</b> ADDRESS <b></b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Richard A. Brady</b>					
SINGLETON FUNERAL HOME, GLENBURNIE, MD. <b>AUG 2 1979</b>													



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 7 9 1 6 0 9 3 DST

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
LOUISE KATHERINE PRIEBE		JULY 22, 1979		8:00P M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Caucasian	Aug. 10, 1906	72	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore, Md.	USA		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Westinghouse		Retired
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	AA	Glen Burnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	203 Ferndale Avenue	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
William Ernest Lotz		Louise Brettschneider			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		215-01-2362	Frederick W. Priebe, Sr. same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the 1519 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a), stating the } underlying cause last. } (b) } (c) } DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) COOPD, Emphysema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7 19 76, to 7/22 19 79, that (I) (we) last saw the deceased alive on 7/22 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Robert Krausnick		22c. DATE SIGNED 7/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
Robert Krausnick		205 Bellvue Angelis Pl			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		26 July 79	Meadowridge Mem.	Elkridge, Howard, Md.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D BY REGISTRAR	
James S. Kirkley, Glen Burnie, Md.				JUL 24 1979	

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH.

REG. NO.

7916094

1. DECEASED NAME (TYPE OR PRINT) <b>IRVIN T. PRINCE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 10, 1979</b>			2b. HOUR DST <b>8:55A M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 20, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AA Com. Call.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles T. Prince</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine James</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216 12 7084</b>		17. INFORMANT <b>Katherine Carlisle Balto., Md. 21227</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Dementia</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic Unidentified Cancer</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>78</b> , to <b>March 10</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>March 9</b> , 19 <b>1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gelsimo A. Cruz</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/10/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GELSIMO A. CRUZ, M.D.</b>						22e. ADDRESS <b>815 RITCHIE HWY., #106 SEVERNA PARK, MARYLAND 21146</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 13, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home of Brooklyn Balto., Md. 21225</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1979</b>			

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DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 6 0 9 5			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Liselrae I		Prince						July 14 1979		5	55	PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		caucasian		8 4 22		56 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
N. JERSEY		USA				Anne Arundel County MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel General Hospital		State of MD.		Ret.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
md		Anne Arundel		edgewater		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		126 Riverside Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Raymond		Thiff		HOUSE HAUSMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		135-14-2206		ROBERT C. PRINCE		#13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CAD, breast & metastasis													
1749													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
n. Breen for S. Wathen				7/14/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
ROBERT B. BERN		151 CATHARAL ST. ANNAPOLIS MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE			
CREMATION		7/16/79		Ft. Lincoln		BREWSTER		PG		MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
John M. L. ...		Cimprich md		JUL 18 1979		[Signature]							

MEDICAL CERTIFICATION

1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VRA 15 ME (5))  
30M 7/73

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16096	
1. DECEASED NAME (TYPE OR PRINT) <b>VIVIAN Elizabeth RADULEWICZ</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 26 1979										2b. HOUR A M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 4 21 57		6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 7 26 1979		2d. HOUR A M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co MD									
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hosp, Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife				12b. KIND OF BUSINESS OR INDUSTRY own home									
13a. STATE MD										13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1207 Wilson Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST William Reese										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie B. Robison											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. XXXXXXX 212/12/4691		17. INFORMANT ADDRESS same as 13 Mr. Pete Radulewicz (husband)															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4029														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>E. Linhardt</i>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER <i>Chenopolis, Ind</i>				DATE SIGNED 7.26.79									
EXAMINER'S NAME (TYPE OR PRINT) E. Linhardt				ADDRESS <i>Chenopolis, Ind</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 30, 79		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD											
24. FUNERAL DIRECTOR NAME R. N. Hopkins										25a. DATE REC'D. BY REGISTRAR JUL 27 1979		25b. REGISTRAR'S SIGNATURE <i>Henry McCready</i>									
26. FUNERAL HOME Singleton Funeral Home, Glen Burnie, MD																					

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RECEIVED

(M)

Handwritten notes and signatures at the top of the page, including a date that appears to be 10/10/10.

Handwritten notes in the middle section of the page.

Handwritten notes and a signature in the lower middle section of the page.

Handwritten notes and a signature at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 6 0 9 7

1. DECEASED NAME (TYPE OR PRINT) William Jennings Bryan Reid			2a. DATE OF DEATH MONTH DAY YEAR July 23 1979			2b. HOUR 10:25 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 1 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AA Co MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter			12b. KIND OF BUSINESS OR INDUSTRY Grocery		
13a. STATE Md			13b. COUNTY AA Co		13c. CITY OR TOWN Shady Side		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4910 Lerch Drive		
14. FATHER'S NAME FIRST MIDDLE LAST Ernest N. Reid						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Hunter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578 05 0946		17. INFORMANT ADDRESS Edwin Reid, Shady Side, Md 20867					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF LUNG.</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1976</u> , 19 <u>76</u> , to <u>JULY 23</u> , 19 <u>79</u> , that (I) (we) <u>last</u> saw the deceased alive on <u>JULY 14</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harvey J. Steinfeld</u> MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>7/24/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HARVEY STEINFELD</u>						22e. ADDRESS <u>Shady Side Md 20867</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-26-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Co Md			
24. FUNERAL DIRECTOR NAME <u>Hardesty FH, 12 Ridgely Ave, Annapolis, Md 21401</u>						25a. DATE REC'D BY REGISTRAR <u>JUL 25 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Ritony McBrady</u>			

SEP 01





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 6 0 9 8 REG. NO.		DST					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY ELLEN RHODES</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 1, 1979</b>			2b. HOUR <b>4:10 A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 19 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Bus Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Fred.</b>		13c. CITY OR TOWN <b>Fred.</b>		13e. STREET ADDRESS <b>Rt. 12 Box 147 Fred., Md.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Robert Hood</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Sophia Hanners</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-18-8063</b>		17. INFORMANT <b>Chas. L. Rhodes Rt. 12 Box 147 Fred. Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHF, Arrhythmias, septal defect</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Shock due to cholecystitis &amp; pancreatitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>5/30/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ACUTE ABDOMEN</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.									
22b. SIGNATURE <b>Paul M. Rosoff</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/1/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL M. ROSOFF, M.D.</b>		22e. ADDRESS <b>425 RITCHIE HIGHWAY, S.E. GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fred. Fred. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>G. Douglas Stauffer Rt. 10 Box 66 Fred., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara M. Brady</b>			

BP

DAUL M. ROBERT, M.D.

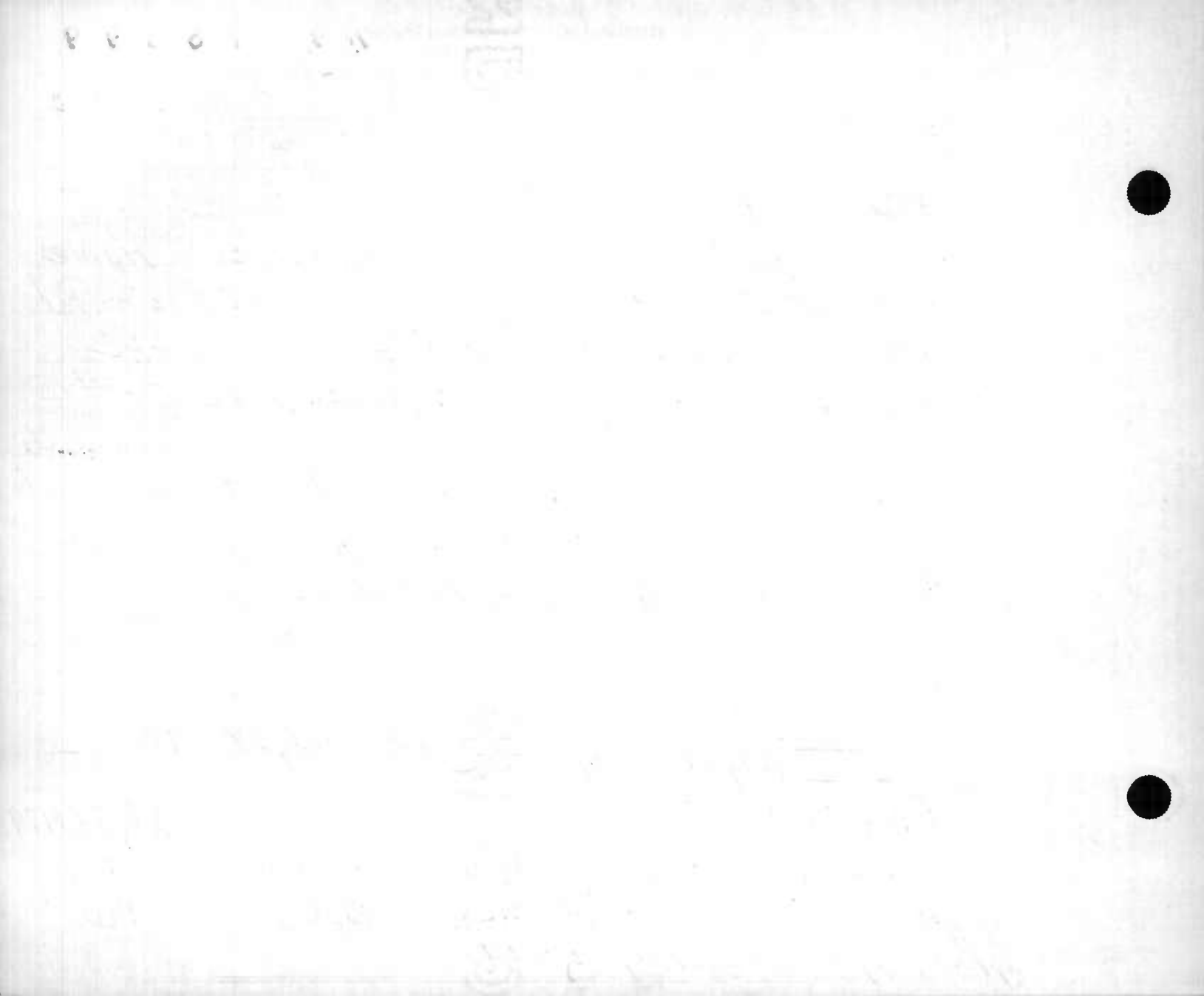
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 7 9 1 6 0 9 9							
1. DECEASED NAME (TYPE OR PRINT) EDNA A RITTERSHOFER			2a. DATE OF DEATH 7-28-1979			2b. HOUR 10 A.M.				
3. SEX F		4. RACE W		5. DATE OF BIRTH 12-11-04			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. CITY OR TOWN Annapolis		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 711 Whitehall Plazins Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Walter W. Marsh Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Herberta Forythe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-0633		17. INFORMANT ERNEST RITTERSHOFER JR. #13					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Coronary artery insufficiency</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>immediate</u> <u>remote</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Aortic valve insufficiency &amp; stenosis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>July 28</u> 19 <u>79</u> , to <u>July 28</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>July 28</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles W. Kinzer			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED July 28, 1979				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer, M.D.			22e. ADDRESS Annapolis, Maryland 21401							
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) BURIAL			23b. DATE 7/31/79		23c. NAME OF CEMETERY OR CREMATORY HOUND PARK		23d. LOCATION BALTO CITY OR TOWN COUNTY STATE MD.			
24. FUNERAL DIRECTOR NAME John M. Lythgoe			ADDRESS Annapolis, Md.			25a. DATE REC'D. BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE Lutero A. Brady		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH7 9 1 6 1 0 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Myrtle I. Robinson			2a. DATE OF DEATH MONTH DAY YEAR July 30, 1979			2b. HOUR 7:35 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-28-94		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	
12b. KIND OF BUSINESS OR INDUSTRY Civil Service		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					
13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 School St.	
14. FATHER'S NAME FIRST MIDDLE LAST John King Gladden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Aurlene Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-16-5212		17. INFORMANT ADDRESS A. Elmer Robinson #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal insufficiency 4039 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months unk.	
--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Recurrent urinary infections, congestive heart failure			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

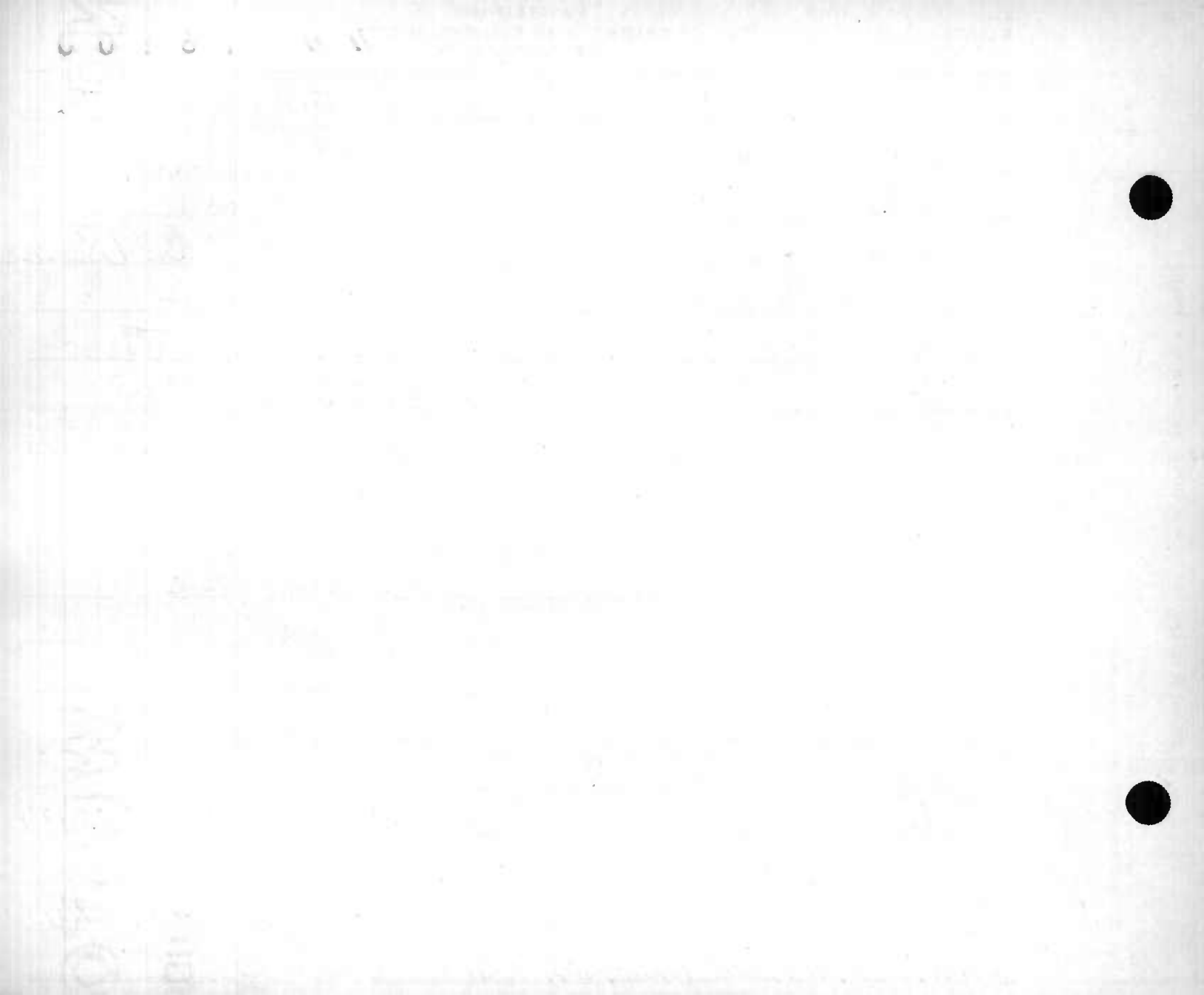
22a. I certify that (I) (this hospital) attended the deceased from 19 75 to July 30, 19 79, that (I) (we) lost saw the deceased alive on July 29, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Charles W. Kinzer DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED July 30, 1979

23a. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer MD 23b. ADDRESS Annapolis, Maryland 21401

23c. BURIAL, CREMATION, REMOVAL (TYPE) Burial 23d. DATE 9/1/79 23e. NAME OF CEMETERY OR CREMATORY St. Annes Cemetery 23f. LOCATION CITY OR TOWN COUNTY STATE A.A. Md.

24. FUNERAL DIRECTOR John M. Taylor, Sons Annapolis, Md. ADDRESS 25a. DATE REC'D. BY REGISTRAR AUG 15 1979 25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 6 1 0 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Nicholas T ROSATI					2a. DATE OF DEATH MONTH DAY YEAR July 27, 1979			2b. HOUR 1:50A M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 9, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY Ret.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Annapolis					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 314 North Taylor Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph G. Rosati					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Felipia Delia				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO 913 160 712		17. INFORMANT Mary Suit		17. ADDRESS 1319 Homewood Ave. Annapolis, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension & atherosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day many years
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>did not</del> attended the deceased from January 20, 1976, to July 27, 1979, that (I) <del>did not</del> saw the deceased alive on July 26, 1979, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> (did) view the body after death.									
22b. SIGNATURE Charles W. Kinzer					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED July 27, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles W. Kinzer, M. D.					22e. ADDRESS 16 Murray Av., Annapolis, Maryland 21401				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/30/79		23c. NAME OF CEMETERY OR CREMATORY St Marys		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD			
24. FUNERAL DIRECTOR NAME John M. Lytle					25a. DATE REC'D. BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE [Signature]		



10101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79 16102	
1. DECEASED NAME (TYPE OR PRINT) <b>EUGENE RUFFINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 25, 1979</b>		2b. HOUR <b>924A</b> M
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 4 01</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>AA</b> 13c. CITY OR TOWN <b>Glen Burnie</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>Box 96 B East Howard Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Ruffin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-34-8210</b>		17. INFORMANT ADDRESS <b>Annie Ruffin Box 96 B East Howard Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> YEARS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>ADULT ONSET DIABETES MELLITUS</b> YEARS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>July 9, 1979</b> to <b>July 25, 1979</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>July 11, 1979</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <b>Loraine M. Dailey M.D.</b>				22c. DATE SIGNED <b>7-26-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. LORANE N. DAILEY</b>				22e. ADDRESS <b>7445A FURNACE BRANCH RD. GLEN BURNIE</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>JUL 31 1979</b>		23f. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>			

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JULY 28, 1950

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16103

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR																													
1. DECEASED NAME (TYPE OR PRINT)										2c. DATE PRONOUNCED DEAD										2d. HOUR																													
FIRST MIDDLE LAST ELMO C. RUPERT										MONTH DAY YEAR 7 1 1979										A M																													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.																																							
F		W		10 12 1912		66 YRS.		MONTHS DAYS HOURS MIN.																																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										9. BALTIMORE CITY OR COUNTY OF DEATH																													
OHIO										USA										ANNE ARUNDEL MD.																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																			
Annapolis										2050 PANNNA RD										HOUSEWIFE										HOME																			
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS									
MD.										AA										Annapolis										YES X NO										2050 PANNNA RD.									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																							
FIRST MIDDLE LAST FRED SMALLEY										FIRST MIDDLE LAST WILLIAM																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																			
YES, NO, OR UNKNOWN										(IF YES, GIVE WAR OR DATES)										220 246841										H.E. Rupert Jr.										H.B. Box 151 BENOLD MD. 21012									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										19. IMMEDIATE CAUSE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I DEATH WAS CAUSED BY:										4292										Interval																													
DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																													
																				YES NO X																													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED																													
										HOUR A.M. MONTH DAY YEAR										(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK										21e. PLACE OF INJURY										21f. LOCATION																													
										(AT HOME, STREET, FACTORY, FARM, ETC.)										STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																																																	
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																													
Edwin H. H. H.										M.D. Depoly										7-2-99																													
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																							
Edwin H. H. H.										Annapolis, Md																																							
23a. BURIAL, CREMATION, REMOVAL										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																			
Burial										7/5/79										Hillcrest										Annapolis AA MD																			
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
John M. Taylor & Sons Annapolis, Md.										JUL 5 1979										L. J. J. J.																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 6 1 0 4 DST		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JAMES SULLIVAN SAUNDERS						JULY 31, 1979		1:10P AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		3-26-1891		88 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL				Ret. Attend.		Naval Acad.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		104 Mission St.	
MD.		A.A.		Pasadena					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Unknown				Elizabeth Jacobs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
YES		WALL		219-16-0605		Laura Saunders - Sec. 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>2898</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Aplastic Anemia with Leucopenia.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myelofibrosis.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASHD: Congestive Heart Failure, Azotemia, Foot Infection, Urinary Tract Infection.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF FACTORY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/31</u> 19 <u>79</u> to <u>7/31</u> 19 <u>79</u> , that (I) (was) lost saw the deceased alive on <u>7/30</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If <del>not</del> (did not) view the body after death.									
22b. SIGNATURE <u>H. R. Bhani</u>				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARI K. BHASIN, M.D.				22e. ADDRESS 1404 CRAIN HIGHWAY, SOUTH GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		8-3-79		Glen Haven Cem		Glen Burnie A.A. Blvd			
24. FUNERAL DIRECTOR NAME Robert J. Barranco				ADDRESS 501 Ritchie Hwy Severna Park		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						AUG 2 1979			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					79 16105	
1. FOR STATE REGISTRAR					REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert A. Scanlon					2a. DATE OF DEATH MONTH DAY YEAR JULY 10, 1979	
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR Oct 15, 1926		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		
10 CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD		
13a. STATE MD		13b. COUNTY A		13c. CITY OR TOWN ORCHARD BEACH		
14. FATHER'S NAME FIRST MIDDLE LAST LEO F SCANLON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE L APPLE		13d. STREET ADDRESS 1016 BEACH PROMADE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 218-22-5220		17. INFORMANT ADDRESS JOANN RAY 132 WILEYS LANE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22. I certify that (I) (this hospital) attended the deceased from 7-2-79, to 7-10-79, that (I) (we) last saw the deceased alive on 7-10-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE J. I. Stern		22c. DATE SIGNED 7-10-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M.D.		
22e. ADDRESS 300 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				
23b. DATE 7/13/79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		
24. FUNERAL DIRECTOR NAME McCully FUNERAL HOME		24b. ADDRESS 130 E. FORT AVE		25a. DATE REC'D. BY REGISTRAR JUL 12 1979		
25b. REGISTRAR'S SIGNATURE Henry McBrady						

BP

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TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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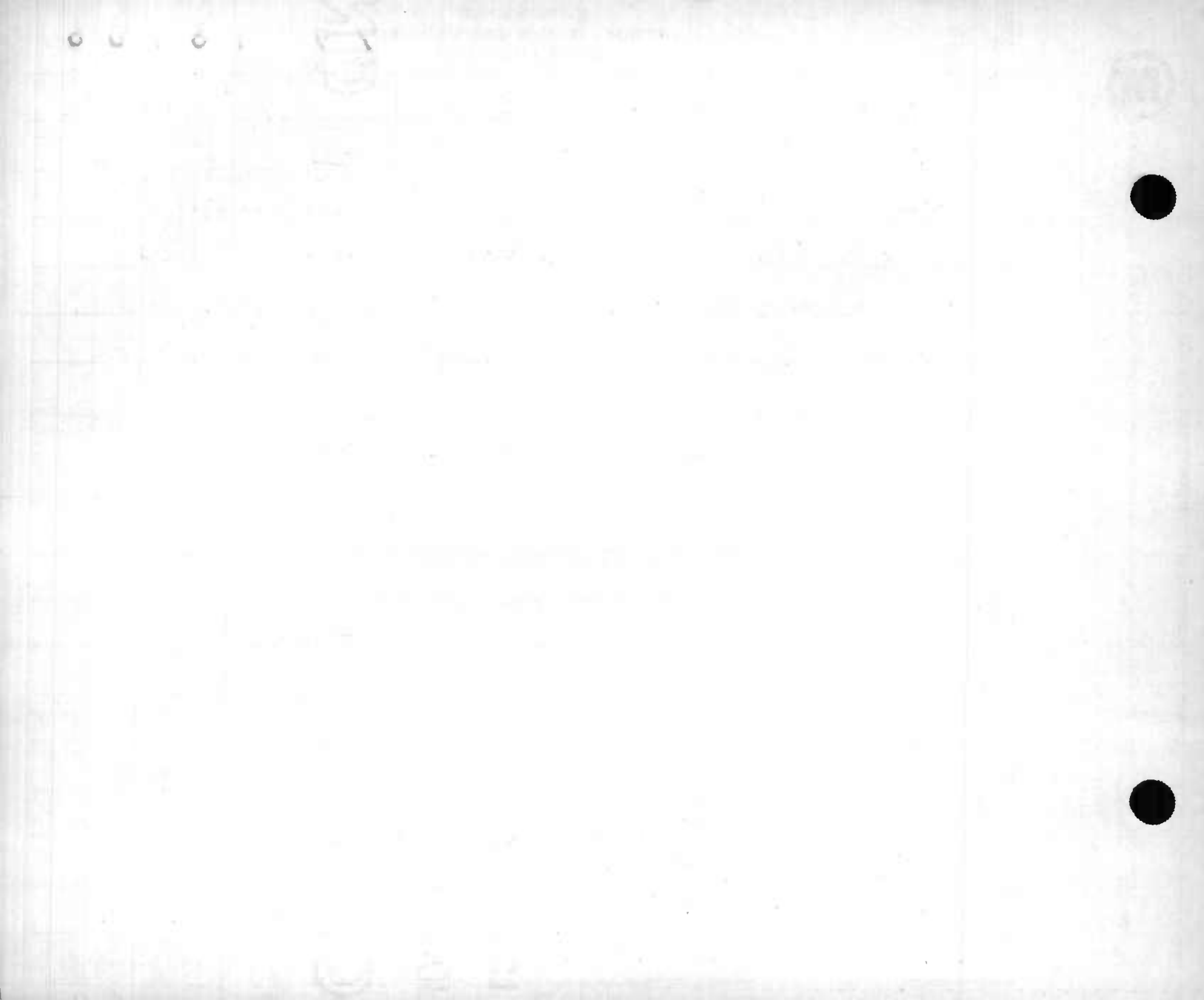
FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 1 0 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL SCHWIEGER</b>			2a. DATE OF DEATH MONTH <b>7</b> DAY <b>22</b> YEAR <b>79</b>			2b. HOUR <b>9a</b>			
3 SEX <b>F</b>		4 RACE <b>Oriental</b>		5 DATE OF BIRTH MONTH <b>7</b> DAY <b>22</b> YEAR <b>1979</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>31</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>2</b> DAYS <b>2</b> HOURS <b>2</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel Co</b> MD.			
11. CITY OR TOWN OF DEATH <b>Annapolis</b>		11a. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NA</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>D.</b> LAST <b>Choi</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Young</b> MIDDLE <b>Sue</b> LAST <b>Schwieger</b>		13e. STREET ADDRESS <b>1839 Arwell Ct. Severn Md. 21144</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NA</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NA</b>		17. INFORMANT ADDRESS <b>NA</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>7651 Immature female</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jonathan M. Sutton</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>7/22/79</b>				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JONATHAN M. SUTTON</b>				22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL, (SPECIFY) <b>Burial</b>		23b. DATE <b>8-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		23d. LOCATION CITY OR TOWN <b>Annapolis</b> COUNTY <b>A.A. Md.</b> STATE		23e. DATE REC'D. BY REGISTRAR <b>AUG 8 1979</b>	
24. FUNERAL DIRECTOR T. NAME <b>A. Hardesty</b> Ann Arbor <b>MD</b> 21401q				25. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

D.S.T.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		7:11 M	
CELESTE A. SEARS		JULY 16, 1979			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	Feb. 13, 1907	72 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
AA Co., Md.	USA		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		17a. USUAL OCCUPATION (TYPE OF WORK, OR MOST OF WORKING LIFE)		17b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Bookkeeper		Retired
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	AA	Glen Burnie	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	214 Oak Lane S.W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
George E. Carter			Carrie S. Penn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
No		722-12-0168	Calvin E. Sears, son, G. B. 21061		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATRIAL FIBRILLATION</u> X YRS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> X YRS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>CONGESTIVE HEART FAILURE; HYPERTENSION</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>7-10-</u> 19 <u>79</u> , to <u>7-16</u> 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>7-16-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Nepomuceno</u>		DEGREE M.D.		22c. DATE SIGNED <u>7-16-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE P. NEPOMUCENO, M.D.		22e. ADDRESS 815 RITCHIE HIGHWAY SUITE 106 SEVERNA PARK, MARYLAND 21146			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		19 July 79	Baldwin Mem. Cem.		Millersville, AA, Md.
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
James S. Kirkley, Glen Burnie, Md.				JUL 18 1979	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

JULY 16, 1959

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CELESTE

James C. ... - 100, 10, 1907

Co., Inc. ...

GREEN BROS. ... NORTH AVENUE HOSPITAL

... 214 Oak Lane ...

... 122 ...

725-12-618 ...

JOSE B. ...  
SEVERNA PARK, MARYLAND

...  
...



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO.

Hubbard  
6108

1. DECEASED NAME (TYPE OR PRINT)		Aubrey M. Seekford		2a. DATE KNOWN OF DEATH ESTIMATED		7 4 1979		2b. HOUR P M	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) LAST BIRTHDAY	7 IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8 IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		7 4 1979 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		North Arundel Hospital		Foreman		Koppers Co.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Md.		Anne Arundel		Glen Burnie				7711 Norfolk Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Simon E. Seekford				Rhufell Cameron					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				218-09-4384		Mrs. Nettie G. Seekford, 7711 Norfolk Rd. 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 4149 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>E. Hubbard</u>				TITLE (SPECIFY) M.D. <u>Physician</u>				DATE SIGNED <u>7-4-79</u>	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS					
E. Hubbard				Chesapeake, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		7/7/79		Meadowridge Mem. Pk.		Howard County, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Balto., Md. 21229				JUL 6 1979		<u>John Hubbard</u>			



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JUL 6 1942

U.S. DEPARTMENT OF THE INTERIOR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 16109

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES</b>			2a. DATE OF DEATH MONTH <b>JULY</b> DAY <b>9</b> YEAR <b>79</b>			2b. HOUR <b>7A</b> MIN <b>00</b>			
3. SEX <b>M</b>		4. RACE <b>N</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>15</b> YEAR <b>1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN <b>00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1121 Eastport Terrace</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1121 Eastport Terrace</b>	
14. FATHER'S NAME FIRST <b>JOSEPH</b> MIDDLE <b>SIMMS</b> LAST <b>SIMMS</b>			15. MOTHER'S MAIDEN NAME FIRST <b>MARTHA</b> MIDDLE <b>HUNT</b> LAST <b>HUNT</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>578-24-6320</b>		17. INFORMANT <b>ANNIE SIMMS</b>				ADDRESS <b>1121 Eastport Terrace</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extreme CACHEXIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>WIDELY INFILTRATED CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>of LUNG</b> Approximate interval between onset and death: <b>4-6 wks</b> <b>1+ yers</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>79</b> to <b>Present</b> 19 <b>79</b> , that (f) (last) saw the deceased alive on <b>6-25</b> 19 <b>79</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) (we) <b>did</b> (did not) view the body after death.									
22b. SIGNATURE <b>Peter F. Verkouw, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>7-10-79</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER F. VERKOUW</b>	
22e. ADDRESS <b>1414 Forest Drive, Annapolis, Md. 21403</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-12-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHIEFS U.M. CHURCH CEME</b>		23d. LOCATION CITY OR TOWN <b>Owensville</b> COUNTY <b>Maryland</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>		ADDRESS <b>Annapolis, Md.</b>		DATE REC'D. BY REGISTRAR <b>JUL 12 1979</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>			



YOUNG, JESSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3  
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DST

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LOUISE		SIMMS		JULY 02, 1979		6:14A	
3 SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Female	Black	09 01 1932		46		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			ANNE ARUNDEL COUNTY MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE	NORTH ARUNDEL HOSPITAL			Housewife		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland	AA	Dorsey		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7292 Race Rsd.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Archie Oliver		Isadore Bowie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		218-88-1980		Mr. Thomas C. Simms 7292 Race Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u>							6 mo
2780 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterial Hypertension</u>							5-6 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) <u>obesity</u>							LC
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>79</u> , to <u>July 29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE DEGREE				22c. DATE SIGNED			
<u>B. B. Brumbaugh MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				7/6/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
B BRUCE BRUMBAUGH				5825 MAIN STREET, ELK RIDGE, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		July 6, 79		Saints Rest Cem.		Harman Maryland 21076	
24 FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Herbert E. Nutter 3035 W. North Ave,				JUL 6 1979		<u>Henry M. Brady</u>	

BP



10110  
JULY 05 1953 8:44  
CIVIS

LOUISE  
Black  
05 01 1933  
ANNE ARNOLD COUNTY  
NORTH ARNOLD HOSPITAL  
Dorsey  
1902  
110-55-1000 Mr. Thomas C. Smith 1202  
110-55-1000 Mr. Thomas C. Smith 1202

BRUCE DRUMBAUGH  
1202 MAIN STREET, ECKRIDGE, MD.  
July 8, 1953  
110-55-1000 Mr. Thomas C. Smith 1202

BRUCE DRUMBAUGH  
1202 MAIN STREET, ECKRIDGE, MD.  
July 8, 1953  
110-55-1000 Mr. Thomas C. Smith 1202

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

16111

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Burlin</b>		FIRST <b>Vincent</b>		MIDDLE <b>Smith</b>		LAST <b>Jr.</b>		2b. DATE KNOWN OF DEATH		MONTH <b>7</b>		DAY <b>12</b>		YEAR <b>1979</b>		2d. HOUR <b>P</b>			
Male <b>M</b>		Race <b>White</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>20</b> YEAR <b>1949</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH <b>7</b> DAY <b>12</b> YEAR <b>1979</b>		2d. HOUR <b>P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.													
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>		12b. KIND OF BUSINESS <b>Local</b>		12c. CARRIERS <b>557</b>											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Odenton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>555 Rita Dr.</b>											
14. FATHER'S NAME FIRST <b>Burlin</b> MIDDLE <b>Vincent</b> LAST <b>Smith, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Martha</b> MIDDLE <b>Lester</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>1950 - 1972</b>		17. INFORMANT (wife) <b>Mrs. Gloria L. Smith</b>		ADDRESS <b>Same as #13</b>													
18. CAUSE OF DEATH (Enter only one cause, not one for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound Skull</b> 9554 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 7 12 1979</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted gun shot wound</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>				21f. LOCATION OF INJURY STREET <b>Rita Dr.</b> CITY OR TOWN <b>Odenton</b> COUNTY <b>ADA</b> STATE <b>MD</b>											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) <b>Deputy</b>				M.D. <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>7.12.79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt</b>				ADDRESS <b>Glen Burnie, Md</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7/16/79</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham Vet. Cem</b>				23d. LOCATION OF CEMETERY OR CREMATORY CITY OR TOWN <b>Cheltenham</b> COUNTY <b>P.G.</b> STATE <b>Md.</b>							
24. FUNERAL DIRECTOR'S NAME <b>R. H. Hopkins</b>				ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1979</b>				25b. REGISTRAR'S SIGNATURE <b>John H. ...</b>							

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 1 1 2

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
GUNHILDA A. SMITH					07 30 79					125 P.M.	
3. SEX	FEMALE		4. RACE	WHITE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)	
						MONTH DAY YEAR				YRS.	
						07 13 04				75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 HRS HOURS MIN.	
New York		U.S.A.				Anne Arundel Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		Anne Arundel Gen'l Hospital		Secretary		Legal					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Md.		A.A. Co.		Annapolis						1055 Norman Dr. 21403	
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST	
Karl				Peterson				Anna		Lilyastrand	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		820.03.5773		Diana W. Shiely,		9218 Starcrest #45 San Antonio, Texas 78217					
II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>		(b) <u>Renal Failure</u>		(c) <u>Breast Cancer with metastases</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						minutes					
						wks					
						months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>7/28</u> , 19 <u>79</u> , to <u>7/30</u> , 19 <u>79</u> , that (1)(we) lost saw the deceased alive on <u>7/30</u> , 19 <u>79</u> , and that in my(our) opinion death occurred on the date and hour and from the causes stated above (1)(we) did not see the body after death.		22b. SIGNATURE <u>James Chaconas M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/30/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>James Chaconas</u>		22e. ADDRESS <u>1521 Ritchie Hwy Arnold, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>8/1/1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Walter Brooks Bradley Inc. Balto., Md.</u>		35a. DATE REC'D. BY REGISTRAR <u>AUG 2 1979</u>		35b. REGISTRAR'S SIGNATURE <u>Hickory McCreedy</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH-16 20M  
(VRS 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 1 1 3

REG. NO. DST

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A.M.	
JAMES NMN SMITH				July 21, 1979		10:45 M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male	Black	7 13 1900		79 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Va.	USA			Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		North Arundel Hospital		Retired			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md		A.A.CO		Glen Burnie		330 B Freetown Road	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
George Smith		Clara Kelley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		213 05 9564		Annie Smith 330 B Freetown Road			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>CUA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-19 19 77, to 7-21 19 79, that (I) (we) last saw the deceased alive on 7-21 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Reed</u> DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL B. PEARLMAN, MD.		22e. ADDRESS 5400 Old Court Rd. Randallstown, Maryland, 21133	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-26-79		23c. NAME OF CEMETERY OR CREMATORY Halls Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Md.	
24. FUNERAL DIRECTOR NAME Isaiiah L. Brown & Son PA 1913 W. Balto. St.				25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony H. Brady</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 6 1 1 4 DST	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LYDIA WILLARD SMITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 12, 1979</b>		2b. HOUR <b>1:05A<sub>M</sub></b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>January 11, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Millersville</b>	13e. STREET ADDRESS <b>261 W. Pasadena Road 21108</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles A. Hohrein</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret A. Spath</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-84-9482</b>		17. INFORMANT ADDRESS <b>Mrs. Lydia M. Gray, 261 W. Pasadena Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4275</b> IMMEDIATE CAUSE (a). <b>Chronic Heart</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Extensive Cholecystitis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Paul M. Rosoff</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL M. ROSOFF, M.D.</b>				22e. ADDRESS <b>425 RITCHIE HIGHWAY, SOUTHEAST GLEN BURNIE, MARYLAND 21061</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/16/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	
23d. LOCATION (CITY OR TOWN) <b>Baltimore</b>		23e. COUNTY <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mc Cully Funeral Home of Pasadena Pasadena, Md. 21122</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 18 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

100 . 1 . 6 . 1

AD:1

JULY 15, 1950

SMITH

WILLARD

LYDIA

ALINE ARNOLD COUNTY,

NORTH ARNOLD HOSPITAL

GLEN BURNIE

PAUL W. ROBERT, M.D.

GLEN BURNIE, MARYLAND 21061

455 SITCHEE HIGHWAY, SOUTHEAST

JUL 18 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR Items 19a & 19b. g535 1- STATE 9/24/79 dad REGISTRAR					7 9 16115 REG. NO. DST					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul L. Staten					2a. DATE OF DEATH MONTH DAY YEAR July 9, 1979			2b. HOUR 8:24P M		
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 3 12 1918		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.				
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY A.A.		13c. CITY OR TOWN MILLERSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GLASCOE STATEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE PRAYER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W.W.II 217-28-1814		17. INFORMANT ADDRESS MARY STATEN 720 Cecil Avenue Millersville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 410- IMMEDIATE CAUSE (a) POSSIBLE acute myocardial DUE TO, OR AS A CONSEQUENCE OF infarction + cardiomyopathy (b) Shock + Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF Myocardial infarction (c) SHOCK coronary bypass surgery									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION Sept 1978		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary occlusion - Johns Hopkins				20a. AUTOPSY? NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7-6-1979, to 7-9-1979, that (I) (we) last saw the deceased alive on 7-9-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Daljit S. Sawhney, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/9/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daljit S. Sawhney, M.D.					22e. ADDRESS 205 Baltimore-Annapolis Blvd. Glen Burnie, Md. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-14-1979		23c. NAME OF CEMETERY OR CREMATORY MD. NAT. MEM. PARK			23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Maryland			
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.				ADDRESS Annapolis, Md.			25a. DATE REC'D. BY REGISTRAR JUL 12 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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### Discussion

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MD, NAT, NEW, FAX 099-11-1

TABLE 1

DM (250 mg)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Department of Health and Mental Hygiene. **Medical Examiner notified.** **IMPORTANT:** If death was unexpected or if there was any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by covering Medical Examiner, Dr. Max C. Frank

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 16116			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Mildred F. Steffan				7-29-79 6:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		4-18-16		63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		U. S. A.				Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel General Hospital		Housewife		Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				13d. STREET ADDRESS			
Penna. Alleghany Library				22 Rose Mary Lane			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Grant E. Huffman				Hattie -- Deitman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No --- 192-05-9431				Frank J. Steffan-22 Rose Mary Lane, Library, Pa. 15129			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebral CONTUSION							
DUE TO, OR AS A CONSEQUENCE OF							
(b) ---							
DUE TO, OR AS A CONSEQUENCE OF							
(c) ---							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
July 8 & July 28		Subdural Hematoma		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. June 15 1979		Car Accident.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/17/79 to 7/29/79, that (I) (we) lost saw the deceased alive on 7/28/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Jack Kushner				M.D.		7/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Jack Kushner, M.D.				20 Ridgely - Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		7/30/79		Cedar Hill Crematory		Suitland (Fr. Geo's) Md.	
24. FUNERAL DIRECTOR NAME				25. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Richard A. Coleman - Upper Marlboro: Maryland 20870				AUG 16 1979		Anthony McCready	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 6 1 1 7									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Marjorie J. Stevens								7-1-79		1A	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
F		W		11-15-95		83					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		USA				Anne Arundel, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel General Hospital						Self Employed		Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		695 Americana Drive, Apt. 46			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Charles Johnson				Minnie F. Fish							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
no				061-20-6812		Mary Jane Lytle, Annapolis, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure - Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/1/79, to 7/1/79, that (I) (we) lost saw the deceased alive on 6/30/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE						22c. DATE SIGNED					
Richard N. Peeler, Md.						7/1/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Richard N. Peeler, Md.						121 Cathedral St., Annapolis, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		07-02-79		Metropolitan Crematory		Alexandria, Arlington, Va.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Beall Funeral Home, 1212 West St., Anna., Md.						JUL 3 1979		L. J. Peeler			

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FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH				2b. HOUR			
Herbert R Stoneburner						Month Day Year				7 18 79			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD				2d. HOUR	
M	W	8/16/19	59 YRS.	MONTHS	DAYS	HOURS	MIN	Month Day Year				7 18 79	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Virginia			USA						D.A. Co				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Huntsville			Huntsville General			Self-employed			--				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INTER-CITY LIMITS			13e. STREET AND NUMBER	
Maryland			Montgomery			Wheaton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			11717 Leona Street,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
John Stoneburner			Cecilia Garner										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
no			none			579-09-9945			Celia Stoneburner-wife-(same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery thrombosis												Death	
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. P.M.			19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER			22b. DATE SIGNED	
EXAMINER'S NAME (Type)			F. L. Phineas			M.D.			7-15-79				
ADDRESS (Street, city, town, or county)													
Arlington Va.													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial		7-21-1979		Columbia Gardens				Arlington Va.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.						JUL 23 1979		P. H. McCreedy					
8434 Ga. Ave., S.S. Md.													

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours

after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Cause Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

101-101

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 6 1 1 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE G. Stoy				2a. DATE OF DEATH MONTH DAY YEAR 7 27 79			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 15 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HAGEN Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEAM-FITTER		12b. KIND OF BUSINESS OR INDUSTRY Ret.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Mont 13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8605 MARYFIELD PLACE	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE MORGAN Stoy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 210 07 4301		17. INFORMANT ADDRESS Phen C. Stoy Edgewater MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LARGE cell Carcinoma of Lung with 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Metastases to Left SHOULDER DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald H. Hislop				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD H. HISLOP				22e. ADDRESS SEVERNA PARK MD.			
23. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 7/31/79		23c. NAME OF CEMETERY OR CREMATORY ST. THOMAS		23d. LOCATION CITY OR TOWN COUNTY STATE Ashville Pa.	
24. FUNERAL DIRECTOR James M. Stryker & Sons Annapolis, Md				25a. DATE REC'D. BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE Jeffrey McBrady	

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FOR Items 19a. &amp; 19b.

1- STATE REGISTRATION No. 8-7-79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 1 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERNEST J. SULLIVAN			2a. DATE OF DEATH MONTH DAY YEAR 7 15 79			2b. HOUR 11:48 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 18, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plasterer		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE MD.				13b. CITY OR TOWN Annapolis		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wellington Sullivan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Jett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, INDICATE BRANCH AND DATES) No		16b. SOCIAL SECURITY NO. 213-14-3185		17. INFORMANT'S NAME AND ADDRESS Marjorie E. Sullivan #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septic shock

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 hrs

5570

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Mesenteric vascular occlusion

24 hrs

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerosis, atrial fibrillation

2 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

aortic valve replacement

MEDICAL CERTIFICATION

19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 7-14, 1979, to 7-15, 1979, that (I) (we) lost saw the deceased alive on 7-15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE K. R. HOLSCHEIT		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-15-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. R. HOLSCHEIT		22e. ADDRESS 104 FORBES ST. Annapolis					

23a. BIRTH, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/19/79		23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE DAVIDSONVILLE A.A. MD.	
24. FUNERAL DIRECTOR NAME John M. Taylor & Sons				ADDRESS Annapolis, MD.		25a. DATE REC'D. BY REGISTRAR JUL 18 1979	
						25b. REGISTRAR'S SIGNATURE R. H. Brady	

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(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7916121			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
BRADLEY G		TONGUE						July 16 1979					3:40 P.M.
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS, LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
MALE	NEGRO		1 10 04		75 YRS		MONTHS		DAYS		HOURS		MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND	U.S.A.				Anne Arundel								MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Annapolis, Md.	Anne Arundel Gen'l Hosp.												
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md.	A.A.		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		40 Pleasant St.						
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME												
CLINTON	AGNES												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
NO			ELVA TONGUE		40 Pleasant St. Annapolis, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Benign prostatic hypertrophy</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Several years</u>			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Chronic Indwelling bladder catheter.</u>													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
NA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-12</u> , 19 <u>76</u> , to <u>7-16</u> , 19 <u>79</u> , that (I) (we) (most) saw the deceased alive on <u>7-16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>Charles W. Kinzer M.D.</u>		22c. DATE SIGNED <u>7-16-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Charles W. Kinzer		Annapolis, Md. 21401											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE				
BURIAL	7-20-1979		PINELAWN MEM. PARK		Annapolis		A.A.		Maryland				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
WILLIAM REESE & SONS MORTUARY, P.A.		Annapolis, Md.		JUL 20 1979		<u>Jeffrey A. Brady</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 6 1 2 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Katharine Toomey</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 6, 1979</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 21, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Annaolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Annaolis Nursing &amp; Convalescent</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Assistant Dental School</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Annaolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Center</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>late Daniel H Toomey</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Ellen McHale</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220 36 5483</b>		17. INFORMANT ADDRESS <b>Dr. Charles E Toomey 2660 Greenbrier Lane Annaolis Md 21101</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b> <b>4370</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerosis, cerebral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>yes.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3mm.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Viral enteritis + Flu Syndrome</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>39 Apr 72 to 6 Jul 79</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>6 Jul 79</b> to <b>6 Jul 79</b> , and that (I) (we) lost <b>the deceased alive on above, (I) (we) (did) (did not) see the body after death.</b>									
22b. SIGNATURE <b>[Signature]</b>		22c. DEGREE <b>MD</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. DATE SIGNED <b>6 Jul 79.</b>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Name]</b>		22g. ADDRESS <b>2083 West St Annap. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 10, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 10 1979 [Signature]</b>	
24. FUNERAL DIRECTOR <b>Harry H. Witzke</b> ADDRESS <b>Columbia Road Ellicott City</b>									



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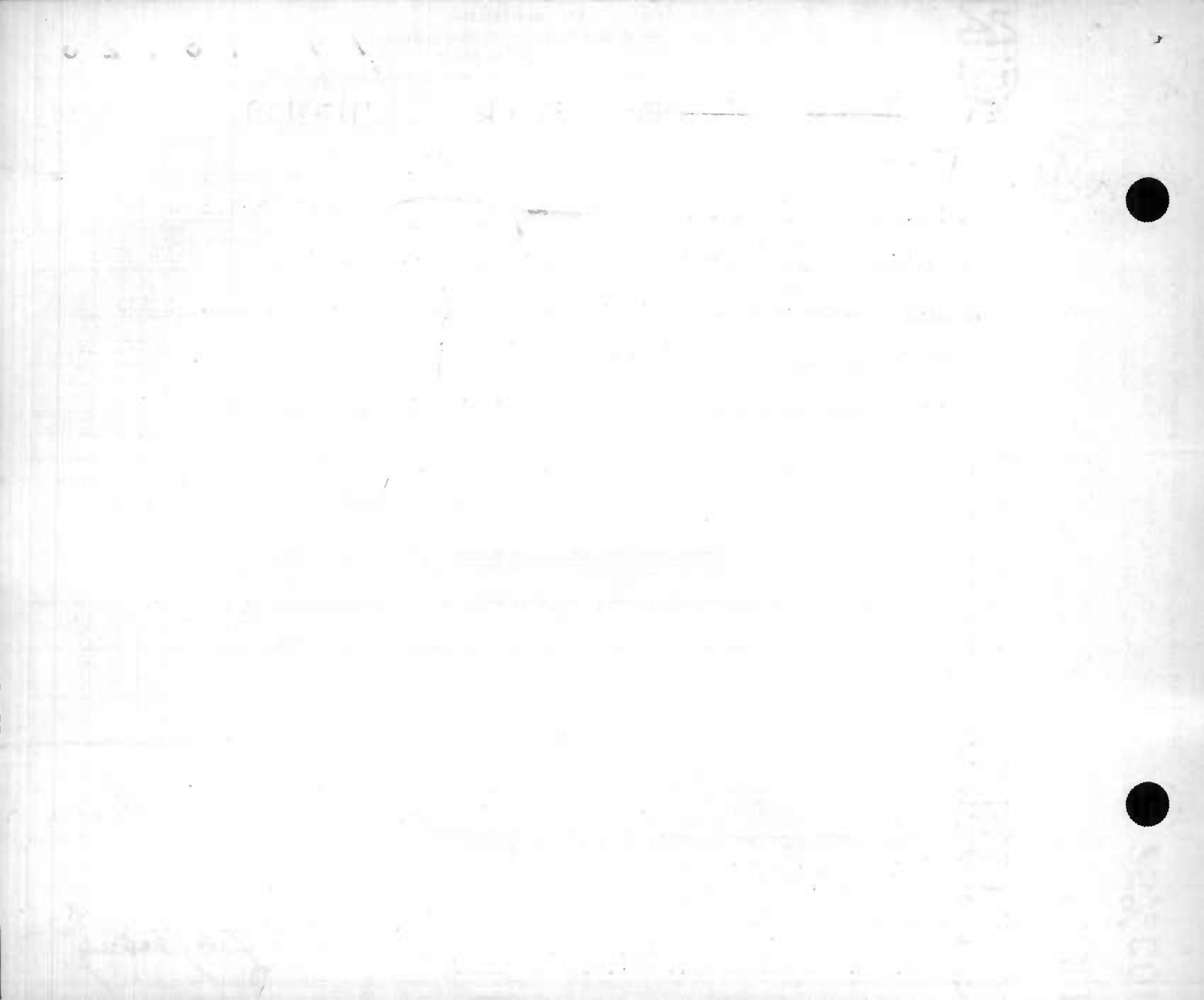
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 6 1 2 3			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Eva Turk Sunxxx Turk				2a. DATE OF DEATH 7/25/79		2b. HOUR 10:5A M	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MAY 14, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10 CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL COUNTY GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL FINGLASS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RAZEL TANNENBAUM					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212349707		17 INFORMANT ADDRESS MRS. ESTHER GUMNIT 4012 SANLEE RD. 21133			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 hr-							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> , 19 <u>79</u> , to <u>7/25</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/25/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR PEELER		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-27-79		23c. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS ANNE ARUNDEL MD	
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR AUG 1 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 1 2 4

FOR 1- STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie S. TYSON		2a. DATE OF DEATH MONTH DAY YEAR 7/4/79 23 <sup>00</sup> M	
3. SEX M	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 3 15 07	
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7c. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Longshoreman	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md		13c. CITY OR TOWN Anne Arundel	
14. FATHER'S NAME FIRST MIDDLE LAST Willie Tyson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Scarborough	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 240-22-0496	
17. INFORMANT Emma Tyson		ADDRESS 68 E. Joyce La.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029 } DUE TO, OR AS A CONSEQUENCE OF (b) } (c) } DUE TO, OR AS A CONSEQUENCE OF PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) COPD, Cilia + prostatic			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
MEDICAL CERTIFICATION			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 67, to 19 present, that (I) (we) lost saw the deceased alive on 6/30/19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE A. Brien		22c. DATE SIGNED 7/5	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR Brien		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-9-79	
23c. NAME OF CEMETERY OR CREMATORY Church Cem.		23d. LOCATION CITY OR TOWN Suffolk Va.	
24. FUNERAL DIRECTOR NAME Carlton C. Douglass		25a. DATE REC'D. BY REGISTRAR JUL 11 1979	
25b. REGISTRAR'S SIGNATURE Anthony McNeely		25c. ADDRESS 669-1738 1012 Penn Ave	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	1 6 1 2 5 DST		
1. FOR STATE REGISTRAR										2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MADELINE J. WADE										MONTH DAY YEAR 7 23 1979		P M 9:00	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.							
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Hair Dresser					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. A.A. Glen Burnie										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6500 N. Charter Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas M. Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha E. Conway								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-14-2975A		17. INFORMANT ADDRESS Thomas Johnson, 618 Washburn Ave.								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>End stage COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) [this hospital] attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Recep Erol</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Recep Erol, M.D.						22e. ADDRESS 325 Hospital Drive #103 Glen Burnie, Md. 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/26/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk., A.A.Co., Md.					
24. FUNERAL DIRECTOR NAME George J. Gonce, 4001 Ritchie Hg., Baltimore						25a. DATE REC'D. BY REGISTRAR JUL 26 1979 REGISTRAR'S SIGNATURE <u>Jeffrey McBrady</u>							

MEDICAL CERTIFICATION

BP

6 2 0 1 1





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 16126

FOR  
1- STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Minnie P. Washington		2a DATE OF DEATH MONTH DAY YEAR 7 24 79		2b HOUR 5:50 P.M.	
3 SEX Female	4 RACE NEGRO	5 DATE OF BIRTH MONTH DAY YEAR 4 8 06		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10 CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Hsg. Center.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a STATE Maryland		13b COUNTY Anne Arund.		13c CITY OR TOWN Shadyside	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH MATTHEWS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH CROWNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 217-30-3439		17 INFORMANT ADDRESS RUTH SPRIGGS 2091 Ropes Drive Annapolis, Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Insufficiency</u> 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dilated cardiomyopathy</u> (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours Mary Jones					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I <del>was</del> <u>did not</u> attend the deceased from <u>5/22, 1979</u> to <u>7/24, 1979</u> , that (I <del>last</del> <u>last</u> saw the deceased alive on <u>7/18, 1979</u> , and that in (my <del>own</del> <u>best</u> ) opinion death occurred on the date and hour and from the causes stated above, (I <del>was</del> <u>did not</u> view the body after death.					
22b. SIGNATURE <u>R. I. Hochman, MD</u>		DEGREE M.D.		22c. DATE SIGNED 7/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. I. Hochman, MD		22e. ADDRESS 16 Murray Ave Annapolis, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-28-1979		23c. NAME OF CEMETERY OR CREMATORY St. Matthews Church Ceme. Shadyside Maryland	
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		ADDRESS Annapolis, Md		25a. DATE REC'D. BY REGISTRAR AUG 02 1979	
				25b. REGISTRAR'S SIGNATURE <u>Fitzroy McCreedy</u>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

0 2 1 0 1 0 1

MEMO

U.S.A.

WASHINGTON

SECRET

REMARKS

NAME

DATE

PLACE

217-30-300 WITH SPECIALS 2000-1-1

UNCLASSIFIED

Initial 1-27-1992 Dr. Matthews (person) (name) (signature) (large)

CLARK & SONS COMPANY, INC.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

D S T

1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL J. WEAVER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 22, 1979</b>			2b. HOUR <b>11:35 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 5, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>606 Mayo Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Johnson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pauline Anderson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>201-12-0945D</b>		17. INFORMANT ADDRESS <b>Mrs. Robert Floyd, same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte imbalance?</b> <b>4392</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic, 2.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/15 1979</b> to <b>7/22 1979</b> , that (I) (we) last saw the deceased alive on <b>7/12 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Anastacio Subong</b>						DEGREE		22c. DATE SIGNED <b>7/23/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANASTACTO SUBONG, M.D.</b>						22e. ADDRESS <b>1406 CRAIN HIGHWAY GLEN BURNIE, MARYLAND 21064</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>27 July 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>North Bend Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>North Bend Clinton Pa.</b>		
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 24 1979</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Elizabeth Katherine Weber</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>July 15, 1979</i>			2b. HOUR <i>8:45 PM</i>				
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 14, 1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County, MD.</i>				
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) <i>107 Thomas Rd. 21061</i>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>107 Thomas Rd. 21061</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Kowalski</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Leonardo Punul</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-07-9036</i>		17. INFORMANT ADDRESS <i>Margaret Langstrom Same as #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal metastatic Carcinoma</i> <i>1991</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>of liver + metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION <i>2/14/79</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>brain tumor</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>7/13</i> 19 <i>79</i> , to <i>7/15</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>7/15</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Paul J. Chang, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>July 16, 1979</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul J. Chang, M.D.</i>			22e. ADDRESS <i>801 Crain Hwy SE, Glen Burnie, Md. 21061</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>7/18/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, Anne Arundel, Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Mc Cully F.H. Mtn. &amp; Tick Neck Rds., Pasadena, Md. 21122</i>			25a. DATE REC'D. BY REGISTRAR <i>JUL 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 1 2 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED MARIE WELSH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-19-79</b>			2b. HOUR <b>2 P.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 18, 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Brooklyn Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hammonds Lane Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3935 Brooklyn Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Rigler</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Franklin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>213-05-3648</b>		17. INFORMANT ADDRESS <b>B Emory T. Welsh same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pneumonia</b> <b>486-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ASCD - Severe Dementia - Parkinson's Disease -</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7-17-79</b> to <b>9-30-79</b> , that (I) (we) last saw the deceased alive on <b>7-17-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/21/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Howard, MD.</b>			
24. FUNERAL DIRECTOR <b>FLECK LAUREL FUNERAL HOME, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
26. ADDRESS <b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>									



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JUL 10 1953

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH16130  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Richard E. West</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7 29 1979</b>			2b. HOUR <b>M</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 29 1956</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>22</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN <b>0 0</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 3 1979</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sandy Point State Park (DOA)</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Warehouse Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Oxon Hill</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wayne A. West</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Bowman</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-72-3256</b>		17. INFORMANT <b>Marjorie L. West</b>				17a. ADDRESS <b>575 Wilson Bridge Dr. Oxon Hill, Maryland</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 8329 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR P.M. <b>7 29 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>fell from boat</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>bay</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Under Bay Bridge A.A. MD</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) <b>Deputy Chief</b> MEDICAL EXAMINER					DATE SIGNED <b>8/4/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>		ADDRESS <b>111 Penn St. Balto., MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. George Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>George P. Kalas Funeral Home Oxon Hill, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 7 1979</b>		25b. RECEIVED BY <i>[Signature]</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR				7 9 1 6 1 3 1 CERTIFICATE OF DEATH REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>WHITE, NADA E.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7 10 79</b>				2b. HOUR <b>4 P</b> M	
3 SEX <b>Female</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 27 19</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>			
10 CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bar</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>				13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>ARNOLD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>410-20-9059</b>		17. INFORMANT ADDRESS <b>Andrew Koontz - Same as Sec 13</b>					
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>pulmonary disease, chronic</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>yes.</b> <b>yes.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1 - 19 79</b> to <b>July 10 - 19 79</b> , that (I) (we) lost saw the deceased alive on <b>July 10 - 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dean Ross</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>7-10-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dean Ross</b>				22e. ADDRESS <b>20 Ridgely Ave, Annapolis, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-13-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey MD.</b>			
24 FUNERAL DIRECTOR NAME <b>Robert S. Barranco</b>				ADDRESS <b>501 Ritchie Hwy Severna Park</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 13 1979</b>		REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 6 1 3 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wendell M. WilleTT				2a. DATE OF DEATH MONTH DAY YEAR 7-2-79				2b. HOUR 12:50 M
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6-1-1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY M.D.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. ST. CITY COUNTY Md. A.A. Annapolis				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 106 Boyd Drive 21403		
14. FATHER'S NAME FIRST MIDDLE LAST Harry C. Willett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula C. Roney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 578-66-0075		17. INFORMANT ADDRESS Norman E. Nozack #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced metastatic carcinoma 1541 } DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of rectum } (c) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last OCT 1978 (diagnosed)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1978	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from Oct 19 78 to 7 2 19 79, that (1) (we) lost saw the deceased alive on 7-1-19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE DEGREE Barber C. Palmer, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-2-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barber C. Palmer, Jr.				22e. ADDRESS Annapolis Md.				
23a. BURIAL, CREMATION, REMOVAL (MAY BE)		23b. DATE 7-2-1979		23c. NAME OF CEMETERY OR CREMATORY F.F. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG. Md.		
24. FUNERAL DIRECTOR NAME John M. Sayla + Sons				ADDRESS Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR JUL 5 1979		
				25b. REGISTRAR'S SIGNATURE Anthony McBrady				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 6 1 3 3										
1- FOR STATE REGISTRAR			REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR						
			Edward		J.		Willey		7		8	79	40							
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.								
Male			White		12 26 98			80 YRS.		MONTHS		DAYS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland			U.S.						Ann Arundel County MD.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Crownsville, Md			Crownsville Hospital Center									Dye Setter		Stamping Co.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS		14. STREET ADDRESS		15. MOTHER'S MAIDEN NAME								
Md			Ann Arundel		Glen Burnie			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16 Mary Lane C-202		Md. 21061								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)									16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS	
William E. B.			Lena			NO									216-07-7649		Mrs. Olga E. Willey		Same as #13c.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Cardiac arrest															2 min					
481- DUE TO, OR AS A CONSEQUENCE OF (b) Left lobar pneumonia, debilitation															3 months					
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
Organic Brain Syndrome, Cerebral Arteriosclerosis + ASCVD																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
			HOUR A.M. MONTH DAY YEAR																	
			P.M. 19																	
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION														
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (his hospital) attended the deceased from 10/2/78, 19 78, to 7/8, 19 79, that (I) (we) last saw the deceased alive on July 8, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED											
Dora Sue Logue, M.D.																				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																	
DORA SUE LOGUE, M.D.			Crownsville State Hospital, Crownsville, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Burial			7-10-79		Cedar Hill Cemetery			Baltimore Anne Arundel Md.			JUL 12 1970			History McCreedy						
24. FUNERAL DIRECTOR			24a. NAME			24b. ADDRESS			24c. CITY OR TOWN			24d. COUNTY			24e. STATE					
Mc Nally Funeral Home of Brooklyn			237 E. Patapsco Avenue			Balto., Md.			21225											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 1 3 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE M LAST WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 7 14 79		2b. HOUR 12 01 AM								
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 28 18		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.							
10. CITY OR TOWN OF DEATH ANNAPOLIS, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland						13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1120 MADISON ST	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE H. BROWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DASIE LANE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-26-0819		17. INFORMANT ADDRESS Annapolis, Md. GLADYS THOMPSON 1115 Madison St. Apt S3							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure H48 DUE TO, OR AS A CONSEQUENCE OF (b) ASCUTD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): 1. Recent Ant-hist MF-779 2. hx of alcoholism													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from August 19 77 to June 19 79, that (I) (we) last saw the deceased alive on June 29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE ERROL A. PHILLIP			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-14-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERROL A. PHILLIP			22e. ADDRESS 20 Ridgely Ave Annapolis Md 21401										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7-17-1979		23c. NAME OF CEMETERY OR CREMATORY BREWER HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland						
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.			ADDRESS Annapolis, Md.			25a. DATE REC'D. BY REGISTRAR JUL 20 1979		25b. REGISTRAR'S SIGNATURE R. J. Kelly					

BP \_\_\_\_\_

H C I O P S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 16135	
1 - STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
A. Joseph Wright				17-5-79				3:30		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
m		W		7-31-13		65 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
St. Louis, Mo.		U.S.A.				Anne Arundel MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel General Hospital				Chief Geographer		Ocean Survey			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS					
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1268 Swan Dr. Rt# 6					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Edward E. Wright				Sarah Dowell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
No				None		491-38-4967 Mrs. Esther Wright (wife) Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 1890 Chanceria of malignancy.											
DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis to lung											
DUE TO, OR AS A CONSEQUENCE OF (c) Renal cell Carcinoma											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
						5121		19 79		July 5 19 79	
22a. I certify that (1) (this hospital) attended the deceased from July 4 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.)											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
George C. Samaras MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				7/5/79			
23a. PHYSICIAN'S NAME (TYPE OR PRINT)				23b. ADDRESS							
George C. Samaras				1616 Forest Drive							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial				7/8/79		Pisgah Cemetery		Newland		Avery N.C.	
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
E. Barnes				Fleming Funeral Service - Benson, Md. 21018				JUL 9 1979		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is not to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 6 1 3 6		REG. NO.		DST			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY	
MILDRED M. YIRKA				July 4, 1979		YEAR		2b. HOUR	
								6:19 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Jan 21 1914		65 YRS.		MONTHS	
								DAYS	
								HOURS	
								MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.				Anne Arundel County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		North Arundel Hospital				Homemaker			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		A.A.		Ferndale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16 second Ave. S.	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Rev. Harry Norris				James L. Yirka same as 13 e					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				James L. Yirka same as 13 e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Primary Pump Failure									
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction									
DUE TO, OR AS A CONSEQUENCE OF (c) Submassive Coronary Artery Occlusion									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-30, 1979, to 7/4, 1979, that (I) (we) lost saw the deceased alive on 7-4-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
HILARY T. O'HERLIHY, MD.								7-8-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
		325 Hospital Drive, #208 Glen Burnie, Maryland, 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		7/7/79		Glen Haven Mem Pk.		Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George J. Gonce		4001 Ritchie Hgwy		JUL 6 1979		Hilary O'Herlihy			



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